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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) 281-8157

Administrative Services Department[11]

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CHAPTER 60
SEPARATIONS, DISCIPLINARY ACTIONS AND REDUCTION IN FORCE

[Prior to 11/5/86, Merit Employment Department[570]]
[Prior to 1986, see Executive Council[420] Ch 10]
[Prior to 1/21/04, see 581—Ch 11]

11—60.1(8A) Separations.

60.1(1) *Resignation, retirement, phased retirement, early retirement, or early termination.*

a. To resign or retire in good standing an employee must give the appointing authority at least 14 calendar days' prior notice unless the appointing authority agrees to a shorter period. A written notice of resignation or retirement shall be given by the employee to the appointing authority, with a copy forwarded to the director by the appointing authority at the same time. An employee who fails to give this prior notice may, at the request of the appointing authority, be barred from certification or appointment to that agency for a period of up to two years. Resignation or retirement shall not be subject to appeal under 11—Chapter 61 unless it is alleged that it was submitted under duress.

Employees who are absent from duty for three consecutive workdays without proper authorization from the appointing authority may be considered to have voluntarily terminated employment. The appointing authority shall notify the employee by registered letter (return receipt requested) that they must return to work within two workdays following receipt of the notification or be removed from the payroll. If the appointing authority receives notice from the U.S. post office that the letter was undeliverable, the employee may be removed from the payroll five days following receipt of that notice. The appointing authority shall consider requests to review circumstances.

b. A full-time employee who is at least 60 years of age and who has completed at least 20 years as a full-time employee may, with approval of the appointing authority, participate in the phased retirement program. The request for participation shall specify the number of hours per week the employee intends to work for each year of the program.

Participants shall be in pay status a maximum of 32 hours per week and a minimum of 20 hours per week during the first four years in the program. After the completion of four years in the program, participants shall be in pay status a maximum of 20 hours per week for the fifth year in the program. An employee may not increase the number of hours in pay status once participation in the program has begun. An employee may participate for a maximum of five years in the program. At the conclusion of the agreed upon period of participation in the program, the employee shall retire from state employment.

An employee participating in the phased retirement program shall receive holiday pay and accrue vacation and sick leave on a pro rata basis in accordance with the number of hours in pay status in the pay period. During the period of participation in the program, all other benefits shall be commensurate with full-time employment.

Participation in the phased retirement program shall serve as a written notice of intent to retire on the date specified in the agreement unless the employee retires, resigns, is discharged, or receives long-term disability prior to that date. Participants are eligible to elect early retirement or early termination incentives in lieu of completing the phased retirement agreement.

An employee who participates in the phased retirement program shall not be eligible to return to permanent employment for hours in excess of those worked at the time of retirement.

c. Employees who received early retirement or early termination incentives provided by 1986 Iowa Acts, Senate File 2242, shall not be eligible for further state employment.

d. Separation from employment for purposes of induction into military service shall be in accordance with 11—subrules 63.6(2) and 63.9(2).

e. A person who has served as a commissioner or board member of a regulatory agency shall not be eligible for employment with that agency until two years after termination of the appointment.

60.1(2) *Expiration of appointment.* When an employee is separated upon the expiration of an appointment of limited duration, the appointing authority shall immediately report the separation to the department on forms prescribed by the director.

60.1(3) *Early retirement incentive program—1992.*

a. This early retirement incentive program is provided for in 1992 Iowa Acts, House File 2454. To be eligible to participate in this program an employee must be at least 59 years of age at the time of termination, have a total of at least 20 years of continuous or noncontinuous membership service, including buy-back or buy-in service, in the Iowa Public Employees' Retirement System (IPERS) or the Public Safety Peace Officers' Retirement, Accident, and Disability System (POR), and be participating in one of the state's group health or dental insurance plans at the time of termination. Employees on the payroll who meet these criteria and who are receiving workers' compensation are also eligible to participate.

b. To be a program participant, employees must complete an early retirement incentive program application form and send it to IPERS or POR prior to November 15, 1992, and must terminate employment no sooner than May 15, 1992, and prior to January 15, 1993. The IPERS address is P.O. Box 9117, Des Moines, Iowa 50306. The POR address is Wallace State Office Building, Des Moines, Iowa 50319.

c. For participating employees, the state's share of the health insurance premium, or the state's share of the dental insurance premium, or both, will continue to be paid by the state. The amount of the state's share will be capped at the amount that was being paid upon termination. The balance of any premium amounts is to be paid by the participating employee. Prior to or after termination, participants may choose to move to a health insurance plan that has a less costly state's share. If the participant moves to a plan with a less costly state's share, the amount paid by the state will be capped at the state's share for the less costly plan. Thereafter, under no circumstances will a previously reduced or capped state's share rate be increased for any participant. The state's share will then continue at that capped rate through the last day of the month prior to the month in which the participating employee reaches age 65.

d. If a program participant dies before reaching age 65, the state's share of health insurance premium, or the state's share of the dental insurance premium, or both, will continue for the dependents who are listed on the employee's health insurance care contract, dental insurance care contract, or both, through the last day of the month prior to the month in which the program participant would have reached age 65. Dependents may then purchase a conversion policy. Contract status changes, i.e., family to single, may occur for the surviving spouse, if applicable.

e. If a program participant or the spouse of a program participant has an event that would change the contract status from family to single, this change will be allowed. In that case, the state's share of the premium will be reduced to and capped at the single plan rate at the time of the contract change. If a program participant has an event that would change the contract status from single to family, this change will be allowed. However, the state's share of the premium will continue at the capped single plan rate. Under no circumstances will a previously reduced or capped state's share rate be increased for any participant.

f. If a program participant has a double-spouse contribution contract at the time of termination, the double-spouse contribution will continue until the earlier of: the death of either spouse, the dissolution or legal separation of these spouses, the last day of the month prior to the month in which the program participant reaches age 65, or the date the remaining working spouse terminates employment.

g. Under no circumstances will a previously reduced or capped state's share rate ever be increased for any participant for any reason.

h. Employees who participate in this program are not eligible to accept any further employment with the state of Iowa. This prohibition does not apply to a program participant who is later elected to public office.

i. Any employee who participates in this early retirement program and who is later approved for state group disability benefits is exempt from further participation in this program. In addition, the state's share of insurance premiums already paid, from the time of termination until long-term disability payments begin, may be recouped by the state and returned to the department of management for repayment to the originating fund. However, any program participant's payment toward health insurance premiums during that period will be applied toward the employee's cost of the coverage.

60.1(4) *Sick leave and vacation incentive program—2002.*

a. This termination incentive program is provided for in 2001 Iowa Acts, Senate File 551. To be eligible to participate in this program an employee's length of credited service and the employee's age as of December 31, 2002, but for participation in this program, must equal or exceed 75 years, including buy-back or buy-in service in the Iowa public employees' retirement system (IPERS) or in the public safety peace officers' retirement, accident, and disability system (POR). Employees on the payroll who meet these criteria and who are receiving workers' compensation on and after November 20, 2001, are also eligible to participate.

(1) Age shall be determined in years and quarters of a year.

1. The birth year is subtracted from 2002 to obtain the total years.

2. To calculate quarters:

- If the birth month is January, February, or March, one year shall be added to the total years calculated in 60.1(4)*"a"*(1)"1";
- If the birth month is April, May, or June, .75 of a year shall be added to the total years calculated in 60.1(4)*"a"*(1)"1";
- If the birth month is July, August, or September, .50 of a year shall be added to the total years calculated in 60.1(4)*"a"*(1)"1";
- If the birth month is October, November, or December, .25 of a year shall be added to the total years calculated in 60.1(4)*"a"*(1)"1."

(2) Length of credited service shall be calculated by IPERS or POR service credit, pursuant to each system's respective rules and regulations.

b. To become a program participant, an employee must complete and file a program application form on or before January 31, 2002, and must terminate employment on or before February 1, 2002.

c. For purposes of this program, the following definitions shall apply:

"Employee" means an employee of the executive branch of the state who is not covered by a collective bargaining agreement, including an employee of a judicial district of the department of correctional services if the district elects to participate in the program, an employee of the state board of regents if the board elects to participate in the program, and an employee of the department of justice. However, "employee" does not mean an elected official.

"Participating employee" means an eligible employee who, on or before January 31, 2002, submits an election to participate in the sick leave and vacation incentive program and terminates state employment on or before February 1, 2002. For the purposes of this program, a person remains a participating employee after payments made hereunder cease.

"Regular annual salary" means the employee's regular biweekly salary on the date of termination multiplied by 26.

d. A participating employee will receive the cash value of the employee's accumulated sick leave, not to exceed 100 percent of the employee's regular annual salary, and annual leave accrued balances. The state shall pay to the participating employee a portion of the combined dollar value of the accrued sick leave and annual leave balances each fiscal year, for a period of five years on the following schedule:

(1) Upon termination, in the first fiscal year of the program, the employee shall receive 10 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(2) In August of the second through the fourth fiscal years of the program, the employee shall receive 20 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(3) In August of the fifth fiscal year of the program, the employee shall receive the remaining 30 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

e. A participating employee, as a condition of participation in this program, shall waive any and all rights to receive payment of a sick leave balance pursuant to Iowa Code section 70A.23 and payment for accrued vacation pursuant to Iowa Code section 91A.4 and shall waive all rights to file suit against the state of Iowa, including all of its departments, agencies, and other subdivisions, based on state or federal claims arising out of the employment relationship.

f. The administrative head, manager, supervisor, or any employee of a department, agency, board, or commission of the state of Iowa shall not coerce or otherwise influence any state employee to participate or not participate in this program.

g. In the event a program participant dies prior to receiving the total cash value of the incentive addressed in paragraph 60.1(4)*"d,"* the participant's designated beneficiary or beneficiaries shall receive the remaining payments on the schedule developed for such payments.

h. An employee who elects participation in this program, from the date of termination from employment, is not eligible to accept any further permanent employment with the state of Iowa. This prohibition does not apply to a program participant who is later elected to public office.

60.1(5) *Sick leave and vacation incentive program—Fiscal Year 2003.*

a. This termination incentive program is provided for in 2002 Iowa Acts, House File 2625. To be eligible to participate in this program an employee's length of credited service and the employee's age as of December 31, 2003, but for participation in this program, must equal or exceed 75 years, including buy-back or buy-in service in the Iowa public employees' retirement system (IPERS) or in the public safety peace officers' retirement, accident, and disability system (POR). Employees on the payroll who meet these criteria and who are receiving workers' compensation on and after July 8, 2002, are also eligible to participate.

(1) Age shall be determined in years and quarters of a year.

1. The birth year is subtracted from 2003 to obtain the total years.

2. To calculate quarters:

- If the birth month is January, February, or March, one year shall be added to the total years calculated in 60.1(5)*"a"*(1)"1";
- If the birth month is April, May, or June, .75 of a year shall be added to the total years calculated in 60.1(5)*"a"*(1)"1";
- If the birth month is July, August, or September, .50 of a year shall be added to the total years calculated in 60.1(5)*"a"*(1)"1";
- If the birth month is October, November, or December, .25 of a year shall be added to the total years calculated in 60.1(5)*"a"*(1)"1."

(2) Length of credited service shall be calculated by IPERS or POR service credit, pursuant to each system's respective rules and regulations.

b. To become a program participant, an employee must complete and file a program application form on or before August 14, 2002, and must terminate employment no earlier than July 8, 2002, but no later than August 15, 2002.

c. For purposes of this program, the following definitions shall apply:

"Employee" means an employee of the executive branch of the state who is not covered by a collective bargaining agreement, including an employee of a judicial district department of correctional services if the district elects to participate in the program, an employee of the state board of regents if the board elects to participate in the program, and an employee of the department of justice, as well as employees eligible to accrue vacation and sick leave within the judicial branch of the state if the judicial branch elects to participate in the program. However, "employee" does not mean an elected official.

"Participating employee" means an eligible employee who, on or before August 14, 2002, submits an election to participate in the sick leave and vacation incentive program and terminates state employment no earlier than July 8, 2002, but no later than August 15, 2002. For the purposes of this program, a person remains a participating employee after payments made hereunder cease.

"Regular annual salary" means (1) for full-time employees, an employee's regular biweekly salary on the date of termination, multiplied by 26; or (2) for part-time employees, the cumulative salary received by the employee during the 26 pay periods immediately prior to termination.

d. A participating employee will receive the cash value of the employee's accumulated sick leave, not to exceed 100 percent of the employee's regular annual salary, and vacation accrued balances. The state shall pay to the participating employee a portion of the combined dollar value of the accrued sick leave and vacation balances each fiscal year, for a period of five years on the following schedule:

(1) Upon termination, in the first fiscal year of the program, the employee shall receive 30 percent of the total cash value of the aforementioned calculation for sick leave and vacation.

(2) In August of fiscal years 2004, 2005 and 2006, the employee shall receive 20 percent of the total cash value of the aforementioned calculation for sick leave and vacation.

(3) In August of fiscal year 2007, the employee shall receive the remaining 10 percent of the total cash value of the aforementioned calculation for sick leave and vacation.

e. A participating employee, as a condition of participation in this program, shall waive any and all rights to receive payment of a sick leave balance pursuant to Iowa Code section 70A.23 and payment for accrued vacation pursuant to Iowa Code section 91A.4 and shall waive all rights to file suit against the state of Iowa, including all of its departments, agencies, and other subdivisions, based on state or federal claims arising out of the employment relationship.

f. The administrative head, manager, supervisor, or any employee of a department, agency, board, or commission of the state of Iowa shall not coerce or otherwise influence any state employee to participate or not participate in this program.

g. In the event a program participant dies prior to receiving the total cash value of the incentive addressed in paragraph 60.1(5)*"d,"* the participant's designated beneficiary or beneficiaries shall receive the remaining payments on the schedule developed for such payments.

h. An employee who elects participation in this program, from the date of termination from employment, is not eligible to accept any further permanent part-time or full-time employment with the state of Iowa. This prohibition does not apply to a program participant who is later elected to public office.

60.1(6) *Sick leave and vacation incentive program—Fiscal Year 2005.*

a. This termination incentive program is provided for in 2004 Iowa Acts, House File 2497. To be eligible to participate in this program, an employee's length of credited service and the employee's age as of December 31, 2004, but for participation in this program, must equal or exceed 75 years, including buy-back or buy-in service in the Iowa public employees' retirement system (IPERS) or in the public safety peace officers' retirement, accident, and disability system (POR). Employees on the payroll who meet these criteria and who are receiving workers' compensation on and after May 21, 2004, are also eligible to participate.

(1) Age shall be determined in years and quarters of a year.

1. The birth year is subtracted from 2004 to obtain the total years.
2. To calculate quarters:

- If the birth month is January, February, or March, one year shall be added to the total years calculated in 60.1(6)*"a"*(1)"1";
- If the birth month is April, May, or June, .75 of a year shall be added to the total years calculated in 60.1(6)*"a"*(1)"1";
- If the birth month is July, August, or September, .50 of a year shall be added to the total years calculated in 60.1(6)*"a"*(1)"1";
- If the birth month is October, November, or December, .25 of a year shall be added to the total years calculated in 60.1(6)*"a"*(1)"1."

(2) Length of credited service shall be calculated by IPERS or POR service credit, pursuant to each system's respective rules and regulations.

b. To become a program participant, an employee must complete and file a program application form on or before May 21, 2004, and must terminate employment no earlier than July 2, 2004, but no later than August 12, 2004.

c. For purposes of this program, the following definitions shall apply:

"Employee" means an employee of the executive branch of this state, including an employee of a judicial district of the department of correctional services if the district elects to participate in the program, an employee of the state board of regents if the board elects to participate in the program, and an employee of the department of justice. However, "employee" does not mean an elected official.

"Participating employee" means an eligible employee who, on or before May 21, 2004, submits an election to participate, and does participate, in the sick leave and vacation incentive program established

by 2004 Iowa Acts, House File 2497. For the purposes of this program, a person remains a participating employee after payments made hereunder cease.

"Regular annual salary" means the employee's regular biweekly salary on the date of termination multiplied by 26.

d. A participating employee will receive an amount equal to the entire value of the employee's accumulated but unused vacation plus the lesser of 75 percent of the value of the employee's accumulated and unused sick leave or 75 percent of the employee's annual salary. The state shall pay to the participating employee a portion of the combined dollar value of the accrued sick leave and annual leave balances each fiscal year, for a period of five years on the following schedule:

(1) Upon termination, in the first fiscal year of the program, the employee shall receive 30 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(2) In August of the second through the fourth fiscal years of the program, the employee shall receive 20 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(3) In August of the fifth and final fiscal year of the program, the employee shall receive 10 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

e. A participating employee, as a condition of participation in this program, shall waive any and all rights to receive payment of a sick leave balance pursuant to Iowa Code section 70A.23 and payment for accrued vacation pursuant to Iowa Code section 91A.4 and shall waive all rights to file suit against the state of Iowa, including all of its departments, agencies, and other subdivisions, based on state or federal claims arising out of the employment relationship.

f. The administrative head, manager, supervisor, or any employee of a department, agency, board, or commission of the state of Iowa shall not coerce or otherwise influence any state employee to participate or not participate in this program.

g. In the event a program participant dies prior to receiving the total cash value of the incentive addressed in paragraph 60.1(6)*"d,"* the participant's designated beneficiary or beneficiaries shall receive the remaining payments on the schedule developed for such payments.

h. An employee who elects participation in this program is not eligible to accept any further permanent part-time or full-time employment with the state of Iowa from the date of termination from employment. This prohibition does not apply to a program participant who is later elected to public office.

60.1(7) *State employee retirement incentive program—Fiscal Year 2010.*

a. This state employee retirement incentive program is provided for in 2010 Iowa Acts, Senate File 2062.

b. To become a program participant, an employee must complete and file a program application form on or before April 15, 2010, and must terminate employment no later than June 24, 2010.

c. For purposes of this program, the following definitions shall apply:

"Employee" means an employee of the executive branch of this state, including an employee of a judicial district of the department of correctional services, an employee of the fair board, an employee of the state board of regents if the board elects to participate in the program, and an employee of the department of justice. However, "employee" does not mean an elected official.

"Eligible employee" means an employee who is employed on February 10, 2010, who is 55 years of age or older on July 31, 2010, and who has submitted an application by the employee's last day of employment to the Iowa public employees' retirement system to begin monthly retirement benefits by July 2010. "Eligible employee" shall include an employee who began receiving IPERS monthly benefits prior to February 2010 if the employee is employed on February 10, 2010, and terminates employment on or before June 24, 2010. "Eligible employee" shall not include an employee who is eligible for the sick leave conversion program as described in Iowa Code section 70A.23, subsection 4, or a former employee who withdraws the application for monthly retirement benefits from the Iowa public employees' retirement system before receiving the first month of benefits.

"Participant" means an eligible employee who, on or before April 15, 2010, submits an application to participate and does participate in the state employee retirement incentive program established by this

subrule. For the purposes of this program, a person remains a participant after all benefits under this program have been made.

"Program" means the state employee retirement incentive program established in 2010 Iowa Acts, Senate File 2062.

"State" means the state of Iowa and all of its branches, departments, agencies, boards, or commissions, including a judicial district department of correctional services and the state board of regents.

d. A participant who elects to remain in the state's retiree health insurance group plan may receive a health insurance contribution benefit. The health insurance contribution benefit consists of up to 5 years of contributions toward retiree health insurance. The contributions shall be used to pay the employer's portion of the health insurance premiums. The department shall determine the contribution rate based on the employer's contribution to an existing state plan.

A participant shall begin receiving the health insurance contribution benefit once payments, if any, under Iowa Code section 70A.23 cease, and shall continue to receive such benefits for 5 years after termination of employment. If a participant is not eligible for payments under Iowa Code section 70A.23, the participant will begin receiving health insurance contribution benefits the month following termination of employment and shall continue to receive such benefits for 5 years after termination of employment.

e. All existing rules and policies regarding continuation of health insurance and changing health insurance plans shall apply to participants and surviving spouses covered by the program.

f. A participant will receive a years of service incentive payment for 5 years after termination of employment. The payments shall include the entire value of the participant's accrued but unused vacation leave and, for participants with at least 10 years of state employment, $1000 for each year of state employment, up to 25 years of employment. State employment shall include all past and present employment with the state, regardless of whether the employee took a refund of the contributions made to IPERS for a prior period of service, if the employee provides adequate documentation of prior periods of employment. The payment shall be paid in five equal installments beginning in September 2010 and ending in 2014.

g. If a participant dies within 5 years of termination of employment, the participant's beneficiary will receive any remaining years of service incentive benefits. If the participant's surviving spouse is covered on the participant's state retiree health insurance plan, the surviving spouse may elect to continue health insurance coverage and will receive any remaining health insurance contribution benefits under this program. If the surviving spouse was not covered by the participant's health insurance plan, or if there is no surviving spouse, any remaining health insurance contribution benefits are forfeited.

h. A participating employee, as a condition of participation in this program, shall waive any and all rights to receive payment for accrued vacation pursuant to Iowa Code section 91A.4 and shall waive all rights to file suit against the state of Iowa, including all of its departments, agencies, and other subdivisions, based on state or federal claims arising out of the employment relationship.

i. The administrative head, manager, supervisor, or any employee of a department, agency, board, or commission of the state of Iowa shall not coerce or otherwise influence any state employee to participate or not participate in this program.

j. A participant is not eligible to accept any further employment with the state, other than as an elected official or a member of a board or commission, from the date of termination from employment. A participant may not enter into a contract to provide services to the state as an independent contractor or a consultant.

k. The state's obligations and duties under Iowa Code chapter 669 are not altered or diminished by a participant's signing of the program application and release form. Participants may pursue any remedy allowed in Iowa Code chapter 669 without regard to program eligibility.

[**ARC 8692B**, IAB 4/21/10, effective 3/29/10; **ARC 8727B**, IAB 5/5/10, effective 4/16/10]

11—60.2(8A) Disciplinary actions. Except as otherwise provided, in addition to less severe progressive discipline measures, any employee is subject to any of the following disciplinary actions when based on a

standard of just cause: suspension, reduction of pay within the same pay grade, disciplinary demotion, or discharge. Disciplinary action involving employees covered by collective bargaining agreements shall be in accordance with the provisions of the agreement. Disciplinary action shall be based on any of the following reasons: inefficiency, insubordination, less than competent job performance, failure to perform assigned duties, inadequacy in the performance of assigned duties, dishonesty, improper use of leave, unrehabilitated substance abuse, negligence, conduct which adversely affects the employee's job performance or the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.

60.2(1) Suspension.

a. Suspension pending investigation. An appointing authority may suspend an employee for up to 21 calendar days with pay pending an investigation. If, upon investigation, it is determined that a suspension without pay was warranted as provided in 60.2(1)*"b"*(1) below for an employee covered by the premium overtime provisions of the Fair Labor Standards Act, the appointing authority shall recover the pay received by the employee for the imposed period of suspension without pay.

b. Disciplinary suspension. An appointing authority may suspend an employee for a length of time considered appropriate not to exceed 30 calendar days as provided in either subparagraph (1) or (2) below. A written statement of the reasons for the suspension and its duration shall be sent to the employee within 24 hours after the effective date of the action.

(1) Employees who are covered by the premium overtime provisions of the federal Fair Labor Standards Act may be suspended without pay.

(2) Employees who are exempt from the premium overtime provisions of the federal Fair Labor Standards Act will not be subject to suspension without pay except for infractions of safety rules of major significance, and then only after the appointing authority receives prior approval from the director. Otherwise, when a suspension is imposed on such an employee, it shall be with pay and shall carry the same weight as a suspension without pay for purposes of progressive discipline. The employee will perform work during a period of suspension with pay unless the appointing authority determines that safety, morale, or other considerations warrant that the employee not report to work.

60.2(2) Reduction of pay within the same pay grade. An appointing authority may reduce the pay of an employee who is covered by the overtime provisions of the federal Fair Labor Standards Act to a lower step or rate of pay within the same pay grade assigned to the employee's class for any number of pay periods considered appropriate. A written statement of the reasons for the reduction and its duration shall be sent to the employee within 24 hours after the effective date of the action, and a copy shall be sent to the director by the appointing authority at the same time.

Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act will not be subject to reductions of pay within the same pay grade except for infractions of safety rules of major significance, and then only after the appointing authority receives prior approval from the director.

60.2(3) Disciplinary demotion. A disciplinary demotion may be used to permanently move an employee to a lower job classification. A temporary disciplinary demotion shall not be used as a substitute for a suspension without pay or reduction in pay within the same pay grade. An employee receiving a disciplinary demotion shall only perform the duties and responsibilities consistent with the class to which demoted. An appointing authority may disciplinary demote an employee to a vacant position. In the absence of a vacant position, the appointing authority may effect the same disciplinary result by removing duties and responsibilities from the employee's position sufficient to cause it to be reclassified to a lower class. A written statement of the reasons for the disciplinary demotion shall be sent to the employee within 24 hours after the effective date of the action, and a copy shall be sent to the director by the appointing authority at the same time.

No disciplinary demotion shall be made from one position covered by merit system provisions to another, or from a position not covered by merit system provisions to one that is, until the employee is approved by the director as being eligible for appointment. Disciplinary demotion of an employee with probationary status to a position covered by merit system provisions shall be in accordance with rule 11—58.2(8A).

An agency may not disciplinarily demote an employee from a position covered by merit system provisions to a position not covered by merit system provisions without the affected employee's written consent regarding the change in coverage. A copy of the consent letter shall be forwarded by the appointing authority to the director. If the employee does not consent to the change in coverage, a reduction in force may be initiated in accordance with these rules or the applicable collective bargaining agreement provisions.

60.2(4) Discharge. An appointing authority may discharge an employee. Prior to the employee's being discharged, the appointing authority shall inform the employee during a face-to-face meeting of the impending discharge and the reasons for the discharge, and at that time the employee shall have the opportunity to respond. A written statement of the reasons for the discharge shall be sent to the employee within 24 hours after the effective date of the discharge, and a copy shall be sent to the director by the appointing authority at the same time.

60.2(5) Termination for failure to meet job requirements. When an employee occupies a position where a current qualification for appointment is based upon the required possession of a temporary work permit or on the basis of possession of a license or certificate, and that document expires, is revoked or is otherwise determined to be invalid, the employee shall either be removed from the payroll for failure to meet or maintain license or certificate requirements, or otherwise appointed to another position in accordance with these rules. This action shall be effective no later than the pay period following the failure to obtain, revocation of, or expiration of the permit, license, or certificate.

When an employee occupies a position where a current qualification for appointment is based upon the requirement of an approved background or records investigation and that approval is later withdrawn or unobtainable, the employee shall be immediately removed from the payroll for failure to maintain those background or records requirements or may be appointed to another position in accordance with these rules.

60.2(6) Appeal of a suspension, reduction of pay within the same pay grade, disciplinary demotion or discharge shall be in accordance with 11—Chapter 61. The written statement to the employee of the reasons for the discipline shall include the verbatim content of 11—subrule 61.2(6).

11—60.3(8A) Reduction in force. A reduction in force (layoff) may be proposed by an appointing authority whenever there is a lack of funds, a lack of work or a reorganization. A reduction in force shall be required whenever the appointing authority reduces the number of permanent merit system covered employees in a class or the number of hours worked, as determined by the "full-time equivalent" funding attributed to the position, by a permanent merit system covered employee in a class, except as provided in subrule 60.3(1).

60.3(1) The following agency actions shall not constitute a reduction in force nor require the application of these reduction in force rules:

a. An interruption of employment for no more than 20 consecutive calendar days, with the prior approval of the director.

b. Interruptions in the employment of school term employees during breaks in the academic year, during the summer, or during other seasonal interruptions that are a condition of employment, with the prior approval of the director.

c. The promotion or reclassification of an employee to a class in the same or a higher pay grade.

d. The reclassification of an employee's position to a class in a lower pay grade that results from the correction of a classification error, the implementation of a class or series revision, changes in the duties of the position, or a reorganization that does not result in fewer total positions in the unit that is reorganized.

e. A change in the classification of an employee's position or the appointment of an employee to a vacant position in a class in a lower pay grade resulting from a disciplinary or voluntary demotion.

f. The transfer or reassignment of an employee to another position in the same class or to a class in the same pay grade.

g. A reduction in the number of, or hours worked by, permanent employees not covered by merit system provisions.

60.3(2) The agency's reduction in force shall conform to the following provisions:

a. Reduction in force shall be by class.

b. The reduction in force unit may be by agency organizational unit or agencywide. If the agency organizational unit is smaller than a bureau, it must first be reviewed by the director.

c. An agency shall not implement a reduction in force until it has first terminated all temporary employees in the same class in the reduction in force unit, as well as those who have probationary status in the same class.

d. The appointing authority shall develop a plan for the reduction in force and shall submit that plan to the director for approval in advance of the effective date. The plan must be approved by the director before it can become effective. The plan shall include the reason(s) for and the effective date of the reduction in force, the reduction in force unit(s), the reason(s) for choosing the unit(s) if smaller than a bureau, the number of permanent merit system covered employees by class to be eliminated or reduced in hours, the cutoff date for length of service and performance credits to be utilized in determining retention points, and any other information requested by the director. The appointing authority shall post each approved reduction in force plan for 60 calendar days in conspicuous places throughout the reduction in force unit. The posting shall include the names of all permanent merit system covered employees for each affected job class in the reduction in force unit by retention point order.

e. The appointing authority shall notify each affected employee in writing of the reduction in force, the reason(s) for it, and the employee's rights under these rules. A copy of the employee's retention points computation worksheet shall be furnished to the employee. The official notifications to affected employees shall be made at least 20 workdays prior to the effective date of the reduction in force unless budgetary limitations require a lesser period of time. These official notifications shall occur only after the agency's reduction in force plan has been approved by the director, unless otherwise authorized by the director.

f. The appointing authority shall notify the affected employee(s), in writing, of any options or assignment changes during the various steps in the reduction in force process. In each instance the employee shall have five calendar days following the date of receipt of the notification in which to respond in writing to the appointing authority in order to exercise the rights provided for in this rule that are associated with the reduction in force.

60.3(3) Retention points. The reduction in force shall be in accordance with total retention points made up of a combination of points for length of service and points for performance record. A cutoff date shall be set by the appointing authority beyond which no points shall be credited. Length of service and performance credits shall be calculated as follows:

a. Credit for length of service shall be given at the rate of one point for each month of employment, including employment credited to the employee during a probationary period. Any period of 15 calendar days of service in a month will be considered a full month. In computing length of service credit, the appointing authority shall include all continuous merit system covered nontemporary service in the executive branch. If a merit system covered nontemporary employee's employment is interrupted due to (1) a reduction in force, (2) qualification for long-term disability, or (3) a work-related injury, and the employee is subsequently reinstated to the same class in a different layoff unit or to a different class than that held at the time of separation in accordance with rule 11—57.5(8A), and the reinstatement occurs within two years of the interruption of employment, prior service credit shall be restored. Such credit will be subject to a reduction for the period of separation from state service.

Length of service credit shall not include the following periods:

(1) Any period of temporary or seasonal employment, if not credited toward the probationary period.

(2) Any period of suspension without pay of 15 days or more.

(3) Approved leaves of absence without pay in excess of 15 days.

(4) Any period of layoff of 15 days or more.

(5) Any period of long-term disability of 15 days or more.

(6) Any period of unpaid absence that was not subsequently used to establish or adjust the employee's date of hire.

b. Credit for the performance record shall be calculated using the results of documented performance evaluations completed in accordance with 11—subrule 62.2(2) as follows:

(1) A performance evaluation period rated overall as "less than competent" or "does not meet expectations" or for which the "overall sum of ratings" is less than 3.00 shall receive no credit.

(2) A performance evaluation period rated overall as "competent" or better, or "meets or exceeds expectations" or for which the "overall sum of ratings" is 3.00 or greater shall receive one retention point for each month of such rated service.

All employees shall be evaluated for performance in accordance with 11—subrule 62.2(2). If the period covered on the evaluation exceeds 12 months, the rating shall apply only to the most recent 12 months of the period. If the period covered by the evaluation exceeds 12 months and the employee's overall rating mandates the receipt of no credit pursuant to 60.3(3)*"b"*(1), then that overall rating shall apply only to the first 12 months of the period and the remaining months shall be rated as competent. Time spent on approved military leave, workers' compensation leave, or educational leave with or without pay that is required by the appointing authority shall be counted as competent performance.

c. The total retention points shall be the sum that results from adding together the total of the length of service points and the total of the performance record points.

60.3(4) Order of reduction in force. Permanent merit system covered employees in the approved reduction in force unit shall be placed on a list in descending order by class beginning with the employee having the highest total retention points in the class in the layoff unit. Reduction in force selections shall be made from the list in inverse order regardless of full-time or part-time status. If two or more employees have the same combined total retention points, the order of reduction shall be determined by giving preference in the following sequence:

a. The employee with the highest total performance record points; and then, if still tied,

b. The employee with the lower last four digits of the social security number.

60.3(5) Bumping (class change in lieu of layoff). Employees who are affected by a reduction in force may, in lieu of layoff, elect to exercise bumping rights.

a. Employees who choose to exercise bumping rights must do so to a position in the applicable reduction in force unit. Bumping may be to a lower class in the same series or to a lower formerly held class (or its equivalent if the class has been retitled) in which the employee had nontemporary status while continuously employed in the state service. Bumping shall not be permitted to classes from which employees were voluntarily or disciplinarily demoted. Bumping by nonsupervisory employees shall be limited to positions in nonsupervisory classes. Bumping to classes that have been designated as collective bargaining exempt shall be limited to persons who occupy classes with that designation at the time of the reduction in force. Bumping shall be limited to positions covered by merit system provisions and positions covered by a collective bargaining agreement. The director may, at the request of the appointing authority, approve specific exemptions from the effects of bumping where special skills or abilities are required and have been previously documented in the records of the department of personnel as essential for performance of the assigned job functions.

b. When bumping as set forth in paragraph *"a"* of this subrule, the employee shall indicate the class, but the appointing authority shall designate the specific position assignment within the reduction in force unit. The appointing authority may designate a vacant position if the department of management certifies that funds are available and after all applicable contract transfer and recall provisions have been exhausted. The appointing authority shall notify the employee in writing of the exact location of the position to which the employee will be assigned. After receipt of the notification the employee shall have five calendar days in which to notify the appointing authority in writing of the acceptance of the position or be laid off.

Bumping to another noncontract class in lieu of layoff shall be based on retention points regardless of full-time or part-time status and shall not occur if the result would be to cause the removal or reduction of an employee with more total retention points. If bumping occurs, the employee with the least total retention points in the class shall then be subject to reduction in force.

Bumping to another class in lieu of layoff from a class covered by a collective bargaining agreement to a class not covered by a collective bargaining agreement, or vice versa, shall only occur if the move

can be accomplished in accordance with the reduction in force order (retention points or seniority date) governing the class into which the employee moves.

Pay upon bumping shall be in accordance with 11—subrule 53.6(11).

60.3(6) Recall. Eligibility for recall shall be for one year following the date of the reduction in force.

a. The following employees or former employees are eligible to be recalled:

(1) Former employees who have been laid off.

(2) Employees who have bumped in lieu of layoff.

(3) Employees whose hours have been reduced, constituting a reduction in force.

b. Current employees who exercised bumping rights in accordance with subrule 60.3(5) and former employees terminated due to layoff in accordance with subrule 60.3(6) shall only be on the recall list for the class and layoff unit occupied at the time of the reduction in force.

c. The following provisions shall apply to the issuance and use of recall lists:

(1) Recall lists shall be issued for merit system covered positions and contract-covered positions only.

(2) When one or more names are on the recall list for a class in which a vacancy exists, the agency must fill that vacancy with a former employee from that list. If no one from a recall list is selected, the agency shall justify that decision to the director before the position may be filled by other methods.

(3) The recall alternatives in (2) above must be exhausted before other eligible lists may be used to fill vacancies.

d. Recall shall be by class without regard to an employee's status at the time of layoff (full-time or part-time).

An employee may remain on the recall list for the same status as that held at the time of layoff after having declined recall to a position with a different status. However, the employee will be removed for the status declined.

e. One failure to accept appointment to a nontemporary position with the same status as that held prior to the reduction in force shall negate all further recall rights.

f. An appointing authority may refuse to recall employees who do not possess the documented special skills or abilities required for a position, with the prior approval of the director.

g. Notice of recall shall be sent by certified mail, restricted delivery. Employees must respond to an offer of recall within five calendar days following the date the notice was received. A notice that is undeliverable to the most recent address of record will be considered a declination of recall. The declination of a recall offer shall be documented in writing by the appointing authority, with a copy to the director.

h. Vacation accrual and accrued sick leave of recalled employees shall be in accordance with 11—subrule 63.2(2), paragraph *"l,"* and 11—subrule 63.3(10), respectively.

i. An employee who bumps in lieu of layoff or has a work hours reduction, and subsequently leaves employment for any reason, shall be removed from the recall list.

j. Employees who are recalled shall be removed from the recall list unless otherwise provided for in these rules.

k. Pay upon recall shall be in accordance with rule 11—53.6(8A).

60.3(7) Reduction in force shall not be used to avoid or circumvent the provisions or intent of 2003 Iowa Code Supplement section 8A.413, or these rules governing reclassification, disciplinary demotion, or discharge. Actions alleged to be in noncompliance with this rule may be appealed in accordance with 11—Chapter 61.

These rules are intended to implement 2003 Iowa Code Supplement section 8A.413.

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1 Effective date of amendment to 11.1(1) delayed 70 days by Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83. See details following chapter analysis.

2 IAB Personnel Department

3 Effective date of amendments to 7.3(1), 7.12(19A), 11.3(1)*"a,"* 11.3(2)*"d"* and *"e,"* 11.3(4), 11.3(5), 11.3(6)*"c"* and 11.3(6)*"l"* delayed 70 days by the Administrative Rules Review Committee at its meeting held May 13, 1992; delay lifted by the Committee at its meeting held June 10, 1992. See emergency adopted amendment to 11.3(6)*"c"* and *"d,"* 5/27/92 Iowa Administrative Bulletin, pages 2203 and 2204.

CIVIL RIGHTS COMMISSION[161]

CHAPTER 1
RULES OF PRACTICE

CHAPTER 2
GENERAL DEFINITIONS

CHAPTER 3
COMPLAINT PROCESS

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CHAPTER 11
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CHAPTER 1
RULES OF PRACTICE

[Prior to 1/13/88, see Civil Rights 240—1.2, Ch 9, Ch 10]

161—1.1(216) Organization and administration.

1.1(1) *Organization.*

a. Commission. The Iowa civil rights commission is a seven-member body. Members are appointed by the governor pursuant to Iowa Code section 216.3.

b. Location. The Iowa civil rights commission, hereinafter referred to as "commission," is located on the First Floor, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-1004; telephone (515)281-4121; toll-free in Iowa only 1-800-457-4416; facsimile transmission (fax) (515)242-5840. Office hours are 8 a.m. to 4:30 p.m. Monday through Friday, or the business hours set by the office of the governor or otherwise established by the legislature.

1.1(2) *Administration.* The executive director is responsible for the day-to-day administration of the commission's activities.

1.1(3) *Electronic attendance of commissioners.*

a. Notification. A commissioner wishing to attend the commission meeting by electronic means shall notify the executive director of this intent. The executive director will then take all reasonable measures to ensure that the necessary equipment is available at the site selected for the commission meeting. The commissioner attending by electronic means is responsible for ensuring that adequate equipment is available at the commissioner's location.

b. Public participation. Whenever any commissioners attend by electronic means, public access to the conversation of the commission will be allowed at the location of at least one of the commissioners. Unless good cause requires otherwise, the location where public access to the conversation is provided shall be a location reasonably accessible to the public. If the location is not reasonably accessible to the public, the nature of the good cause justifying inaccessibility shall be stated in the minutes.

c. Electronic attendance of multiple commissioners. If at the time a commissioner notifies the executive director of the intent to attend electronically that commissioner's electronic attendance would mean that four or more commissioners would be attending separately via electronic means, then that commissioner may not attend by electronic means unless the in-person attendance of any four of the commissioners attending the meeting at any of the available meeting sites is impossible or impracticable.

d. Conducting electronic meeting. Whenever four or more commissioners are separately attending a commission meeting by electronic means, the commission shall conduct the meeting in accordance with the following requirements:

(1) The commission shall keep detailed minutes of all discussion, all persons present and all action. The commission shall electronically record all proceedings in the meeting and retain such recordings for no less than one year from the date of the meeting.

(2) The minutes of the meeting shall include a statement explaining why a meeting in person was impossible or impracticable.

(3) The public notice of the meeting shall state the location of the meeting to be the location where public access to the conversation is provided.

[**ARC 8749B**, IAB 5/5/10, effective 6/9/10]

161—1.2(216) Commission procedure for rule making.

1.2(1) *Initiation of rule-making procedures.*

a. Any person or state agency may file a petition for rule making with the commission at its location as defined in 161—paragraph 1.1(1)"*b*." A petition is deemed filed when it is received by that office. The commission shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the commission an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA CIVIL RIGHTS COMMISSION

Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	}	PETITION FOR RULE MAKING

The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the commission's authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner's arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

b. The commission shall act upon the request within 60 days after its submission in accordance with Iowa Code section 17A.7 as amended by 1998 Iowa Acts, chapter 1202.

c. The commission may initiate rule-making procedures upon its own motion in accordance with Iowa Code section 17A.4.

1.2(2) *Advice on possible rules before notice of proposed rule adoption.* In addition to seeking information by other methods, the commission may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1)*"a,"* solicit comments from the public on a subject matter of possible rule making by the commission by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

1.2(3) *Notice of proposed rule making—contents.* At least 35 days before the adoption of a rule, the commission shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

a. A brief explanation of the purpose of the proposed rule;

b. The specific legal authority for the proposed rule;

c. Except to the extent impracticable, the text of the proposed rule;

d. Where, when, and how persons may present their views on the proposed rule; and

e. Where, when, and how persons may demand an oral proceeding on the proposed rule if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the commission shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by that omitted text of the proposed rule, and the range of possible choices being considered by the agency for the resolution of each of those issues.

1.2(4) *Public participation.*

a. Written comments. For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data, and views, in writing on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to the commission at its location as defined in 161—paragraph 1.1(1)*"b,"* or the person designated in the Notice of Intended Action.

b. Oral proceedings. The commission may, at any time, schedule an oral proceeding on a proposed rule. The commission shall schedule an oral proceeding on a proposed rule if, within 20 days after a published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the commission by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following additional information:

(1) A request by one or more individual persons must be signed by each of them and include the address and telephone number of each of them.

(2) A request by an association must be signed by an officer or designee of the association and must contain a statement that the association has at least 25 members and the address and telephone number of the person signing the request.

(3) A request by an agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing the request.

c. Conduct of oral proceedings.

(1) Applicability. This paragraph applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)*"b"* as amended by 1998 Iowa Acts, chapter 1202, or paragraph 1.2(5)*"f."*

(2) Scheduling and notice. An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

(3) Presiding officer. The commission, a member of the commission, or another person designated by the commission who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule. If the commission does not preside, the presiding officer shall prepare a memorandum for consideration by the commission summarizing the contents of the presentations made at the oral proceeding unless the commission determines that such a memorandum is unnecessary because the commission will personally listen to or read the entire transcript of the oral proceeding.

(4) Conduct of the proceeding. At an oral proceeding on a proposed rule persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the commission at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

1. At the beginning of the oral proceeding the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the commission decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

2. Persons making oral presentations are encouraged to avoid restating matters which have already been submitted in writing.

3. To facilitate the exchange of information the presiding officer may, where time permits, open the floor to questions or general discussion.

4. The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

5. Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the commission.

6. The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

7. Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questions of participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

8. The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to adjournment of the oral presentations.

d. Additional information. In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the commission may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

e. Accessibility. The commission shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the commission at its location as defined in 161—paragraph 1.1(1)"*b*" in advance to arrange access or other needed services.

1.2(5) *Regulatory analysis.*

a. Definition of small business. A "small business" is defined in 1998 Iowa Acts, chapter 1202, section 10.

b. Qualified requesters for regulatory analysis—economic impact. The commission shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4(2a) after a proper request from:

(1) The administrative rules coordinator;

(2) The administrative rules review committee.

c. Qualified requesters for regulatory analysis—business impact. The commission shall issue a regulatory analysis of a proposed rule that conforms to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2b) after a proper request from:

(1) The administrative rules review committee,

(2) The administrative rules coordinator,

(3) At least 25 or more persons who sign the request provided that each represents a different small business,

(4) An organization representing at least 25 small businesses. That organization shall list the name, address and phone number of not less than 25 small businesses it represents.

d. Time period for analysis. Upon receipt of a timely request for a regulatory analysis the commission shall adhere to the time lines described in 1998 Iowa Acts, chapter 1202, section 10(4).

e. Contents for request. A request for a regulatory analysis is made when it is mailed or delivered to the commission. The request shall be in writing and satisfy the requirements of 1998 Iowa Acts, chapter 1202, section 10(1).

f. Contents of concise summary. The contents of the concise summary shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(4,5).

g. Publication of a concise summary. The commission shall make available to the maximum extent feasible, copies of the published summary in conformance with 1998 Iowa Acts, chapter 1202, section 10(5).

h. Regulatory analysis contents—rules review committee or rules coordinator. When a regulatory analysis is issued in response to written request from the administrative rules review committee or the administrative rules coordinator, the regulatory analysis shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2*a*), unless a written request expressly waives one or more of the items listed in the section.

i. Regulatory analysis contents—substantial impact on small business. When a regulatory analysis is issued in response to a written request from the administrative rules review committee, the administrative rules coordinator, at least 25 persons signing that request who each qualify as a small business or by an organization representing at least 25 small businesses, the regulatory analysis shall conform to the requirements of 1998 Iowa Acts, chapter 1202, section 10(2b).

1.2(6) *Fiscal impact statement.*

a. A proposed rule that mandates additional combined expenditures exceeding $100,000 by all affected political subdivisions or agencies or entities which contract with the political subdivisions to provide service must be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement must satisfy the requirements of Iowa Code section 25B.6.

b. If the commission determines at the time it adopts a rule that a fiscal impact statement upon which the rule is based contains errors, the commission shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

1.2(7) *Time and manner of rule adoption.*

a. Time of adoption. The commission shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the commission shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

b. Consideration of public comment. Before the adoption of a rule, the commission shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

c. Reliance on commission expertise. Except as otherwise provided by law, the commission may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

1.2(8) *Variance between adopted rule and published notice of proposed rule adoption.*

a. The commission shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

(1) The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and

(2) The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and

(3) The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

b. In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question the commission shall consider the following factors:

(1) The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;

(2) The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action; and

(3) The extent to which the effects of the rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

c. The commission shall commence a rule-making proceeding within 60 days of receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action upon which the rule is based, unless the commission finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee, within 3 days of its issuance.

d. Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the commission to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

1.2(9) *Concise statement of reasons.*

a. General. When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the commission shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the commission's office as defined in 161—paragraph 1.1(1)*"b."* The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

b. Contents. The concise statement of reasons shall contain:

(1) The reasons for adopting the rule;

(2) An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change;

(3) The principal reasons urged in the rule-making proceeding for and against the rule, and the commission's reasons for overruling the arguments made against the rule.

c. Time of issuance. After a proper request, the commission shall issue a concise statement of reasons by the time the rule is adopted or 35 days after receipt of the request, whichever is later.

1.2(10) *Contents, style, and form of rule.*

a. Contents. Each adopted rule by the commission shall contain the text of the rule and, in addition:

(1) The date the commission adopted the rule;

(2) A brief explanation of the principal reasons for the rule-making action if such reasons are required by Iowa Code section 17A.4(1)*"b"* as amended by 1998 Iowa Acts, chapter 1202, or the commission in its discretion decides to include such reasons;

(3) A reference to all rules repealed, amended, or suspended by the rule;

(4) A reference to the specific statutory or other authority authorizing adoption of the rule;

(5) Any findings required by any provision of law as a prerequisite to adoption or effectiveness of the rule;

(6) A brief explanation of the principal reasons for the failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waiver or special exceptions provided in the rule if such reasons are required by Iowa Code section 17A.4(1)*"b"* as amended by 1998 Iowa Acts, chapter 1202, or the commission in its discretion decides to include such reasons; and

(7) The effective date of the rule.

b. References to materials not published in full. When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the commission shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules, and of significant issues involved in these rules. The summary statement shall also describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter, may be obtained from the commission. The commission will provide a copy of that full text at actual cost upon request and shall make copies of the full text available for review at the state law library and may make the standards available electronically.

At the request of the administrative code editor, the commission shall provide a proposed statement explaining why publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient.

c. Style and form. In preparing its rules, the commission shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

1.2(11) *Filing of rules.* The commission shall file each rule it adopts in the office of the administrative rules coordinator. The filing must be executed as soon after adoption of the rule as is practicable. At the time of filing, each rule must have attached to it any fiscal impact statement and any concise statement of reasons that was issued with respect to that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to the filing of that rule, the note or statement must be attached to the filed rule within five working days after the note or statement is issued. In filing a rule, the agency shall use the standard form prescribed by the administrative rules coordinator.

1.2(12) *Effectiveness of rules prior to publication.*

a. Grounds. The commission may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The commission shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

b. Special notice. When the commission makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3), the commission shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule's indexing and publication. The term "all reasonable efforts" requires the commission to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the following: the effectiveness of the rule under the circumstances, the various alternatives available for this purpose, the comparative costs to the commission of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any one or more of the following means: radio, newspaper, television, signs, mail, telephone, personal notice, or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)*"b"*(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of 1.2(12)*"b."*

1.2(13) *Review by commission of rules.*

a. Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the commission to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the commission shall conduct a formal review of a specified rule to determine whether a new rule should be adopted instead or the rule should be amended or repealed. The commission may refuse to conduct a review if it has conducted such a review of the specified rule within five years prior to the filing of the written request.

b. In conducting the formal review, the commission shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report must include a concise statement of the commission's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any petitions for waiver of the rule received by the commission or granted by the commission. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the commission's report shall be sent to the administrative rules review committee.

[**ARC 8749B**, IAB 5/5/10, effective 6/9/10]

161—1.3(216) Procedures for oral or written presentations.

1.3(1) Except where oral or written presentations are deemed unnecessary by the commission in accordance with section 17A.4(2), the commission shall allow for the submission of oral or written presentations, or both, prior to its adoption of any rules.

1.3(2) Interested persons shall have 20 days from the date of publication of notice in the Iowa Administrative Bulletin to submit written requests for oral presentations or to submit with presentations.

1.3(3) Notice of date, time and place of oral presentations by requesting parties will be published by appropriate media at least 20 days in advance with specific notice to requesting parties given by certified mail.

1.3(4) Interested parties may be limited to submitting written presentations at the discretion of the commission except when oral presentations are required by Iowa Code section 17A.4(1)*"b."*

161—1.4(216) Procedure for obtaining declaratory orders.

1.4(1) *Petition for declaratory order.* Any person may file a petition with the commission for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the commission, at its location as defined in 161—paragraph 1.1(1)*"b."* A petition is deemed filed when it is received by that office. The commission shall provide the petitioner

with a file-stamped copy of the petition if the petitioner provides the commission an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

IOWA CIVIL RIGHTS COMMISSION

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided by 1.4(7).

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

1.4(2) *Notice of petition.* Within 15 days after receipt of a petition for a declaratory order, the commission shall give notice of the petition to all persons not served by the petitioner pursuant to 1.4(6) to whom notice is required by any provision of law. The commission may also give notice to other persons.

1.4(3) *Intervention.*

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 30 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

b. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the commission.

c. A petition for intervention shall be filed at the commission office. Such a petition is deemed filed when it is received by that office. The commission will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

IOWA CIVIL RIGHTS COMMISSION

Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition).	PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

(1) Facts supporting the intervenor's standing and qualifications for intervention.

(2) The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.

(3) Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.

(4) A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.

(5) The names and addresses of any additional persons, or a description of any additional class of persons known by the intervenor to be affected by, or interested in, the questions presented.

(6) Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

1.4(4) *Briefs.* The petitioner or any intervenor may file a brief in support of the position urged. The commission may request a brief from the petitioner, any intervenor, or from any other person concerning the questions raised.

1.4(5) *Inquiries.* Inquiries concerning the status of a declaratory order proceeding may be made to the executive director at the commission's office.

1.4(6) *Service and filing of petitions and other papers.*

a. When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the commission at its location as defined in 161—paragraph 1.1(1)*"b."* All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the Iowa civil rights commission.

c. Method of service, time of filing, and proof of mailing. Method of service shall be by regular mail. Time of filing and proof of mailing shall be as provided by 161—subrule 3.5(8).

1.4(7) *Consideration.* Upon request by petitioner, the commission must schedule a brief and informal meeting between the original petitioner, all intervenors, and the commission, a member of the commission, or a member of the staff of the commission, to discuss the questions raised. The commission may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the commission by any person.

1.4(8) *Action on petition.*

a. Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receipt of a petition for a declaratory order, the executive director or designee shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

b. The date of issuance of an order or of a refusal to issue an order is as defined in Iowa Code section 216.17(1).

c. Within 20 days of the issuance of a declaratory order, the petitioner or intervenors may appeal that order to the commissioners. The commissioners will consider the appeal at a subsequent commissioners' meeting and will either affirm, overturn, or remand the order.

1.4(9) *Refusal to issue order.*

a. The commission shall not issue a declaratory order where prohibited by 1998 Iowa Acts, chapter 1202, section 13(1), and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

(1) The petition does not substantially comply with the required form.

(2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the commission to issue an order.

(3) The commission does not have jurisdiction over the questions presented in the petition.

(4) The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.

(5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.

(6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.

(7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

(8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.

(9) The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.

(10) The petitioner requests the commission to determine whether a statute is unconstitutional on its face.

b. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

c. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

1.4(10) *Contents of declaratory order—effective date.* In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

1.4(11) *Copies of orders.* A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

1.4(12) *Effect of declaratory order.* A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the commission, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the commission. The issuance of a declaratory order constitutes final agency action on the petition.

161—1.5(216) Forms. Forms commonly used by the commission are generally available through the commission's Web site or by telephoning the commission staff.

1.5(1) *"Charge of Discrimination,"* EEOC 5c, for a complaint alleging a discriminatory or unfair practice or act in all jurisdictional areas except housing.

1.5(2) *"Housing Discrimination Complaint,"* HUD 903, for a complaint alleging a discriminatory or unfair practice or act in the jurisdictional area of housing.

1.5(3) *"Authorization Release Form,"* to secure authorization for relevant client information.

1.5(4) *"Administrative Release Form,"* to request a "right to sue" letter.

1.5(5) *"Request for Withdrawal of Charge of Discrimination,"* is used by the complainant to withdraw the charge of discrimination previously filed.

1.5(6) *"Amended complaint,"* to amend the charge of discrimination previously filed.

1.5(7) *"Forms notebook."* Other forms commonly used by the commission or its staff are compiled within a "forms notebook." The notebook is available for inspection by the public at the commission offices. Copies of the forms notebook can be obtained for an appropriate copying charge.

1.5(8) *"Purpose of forms."* The existence of standard forms is for the convenience of the commission, the public, and the parties. The existence of a standard form does not imply that the purpose of the standard form cannot be accomplished through a document in a different form.
[**ARC 8749B**, IAB 5/5/10, effective 6/9/10]

161—1.6(216) Referral and deferral agencies.

1.6(1) *Statement of purpose.* It is the purpose of the commission, in adopting these rules to promote the efficient enforcement of the Act. To this end, the commission will use referral and deferral agreements to encourage agencies with similar powers and jurisdiction to:

a. Develop procedures with remedies necessary to ensure the protection of rights secured by the Iowa Civil Rights Act.

b. Increase the efficiency of their operations.

c. Cooperate more fully with the commission in the sharing of data and resources, and

d. Coordinate investigations and conciliations with the commission in order to eliminate needless duplication.

1.6(2) *Definitions.*

a. *"Agency"* refers to any agency of municipal government established by ordinance for the purpose of eliminating discrimination on any basis protected by the Act or any state or federal governmental unit with jurisdiction over allegations of discrimination that is capable of obtaining remedies similar to those obtainable by the commission.

b. *"Referral"* means the process by which the commission cross-files a charge of discrimination with a referral agency, which extinguishes the legal ability of the commission to process the charge; provided, however, that the referral agency accepts the referred charge and that the commission has the reciprocal right to accept or reject charges cross-filed by the referral agency.

c. *"Referral agency"* means any agency of local government that has been awarded that status by contract with the commission.

d. *"Deferral"* refers to the process whereby the commission notifies an agency of local, state, or federal government that a complaint has been filed with the commission and that the commission will postpone its investigative activities for a period of 60 days while the deferral agency investigates and attempts to resolve the matter. Extensions of this time period may be granted by the commission or the executive director when just cause is shown by the agency for the time extension requested.

e. *"Deferral agency"* means any agency so designated by contract pursuant to these rules.

1.6(3) *Procedure for obtaining referral status.*

a. *Guidelines for designation.* The executive director will evaluate the applications of agencies and may designate agencies as referral agencies where they conform to the following guidelines:

(1) The agency should have professional staff to enable it to comprehensively investigate complaints and to ensure the processing of the charges expeditiously.

(2) The ordinance or enabling legislation under which the agency is established must provide at a minimum the same rights and remedies to discrimination as available under the Act, and

(3) The enabling legislation of the agency shall provide, at a minimum, that the agency may hold public hearings, issue cease and desist orders, and award damages to injured parties which shall include, but are not limited to, actual damages.

b. *Application.* Any agency desiring to be designated as a referral agency by the commission may send a letter of application to the executive director of the commission. Attached to the application must be a copy of the agency's enabling ordinance, a list of its investigatory personnel, the average number of hours worked by each per week, and a report for the previous 12-month period detailing the following:

(1) The number of cases filed with the agency,

(2) The number of probable cause and no probable cause findings,

(3) The number of cases successfully conciliated,

(4) The number of cases taken to public hearing,

(5) The average length of time spent investigating each case,

(6) The cumulative remedies obtained for the previous 12-month period and average remedy obtained per case,

(7) An assessment of the quality of the agency's investigation,

(8) The agency's standards to preserve quality investigations, and

(9) The status of the agency's caseload.

c. Rejection of application. Where the executive director determines that an agency does not qualify as a referral agency, the director shall so inform the agency in writing along with the reasons for the agency's rejection.

If the reasons for the agency's rejection are corrected, the agency will then be designated as a referral agency. The executive director's decision may be appealed to the commission at its subsequent regular meeting.

d. Designation and contract. Where the executive director determines that an agency is qualified as a referral agency, the director will prepare a contract between the commission and the agency containing the terms on which cases will be referred. Upon execution of the contract, the executive director will designate the agency as a referral agency.

e. Terms of the referral contract. The referral contract shall be negotiated with the referral agency, but shall include the following:

(1) Terms prohibiting a complainant who has filed with the commission from cross-filing with a referral agency and vice versa,

(2) Terms permitting the commission to refer complaints filed with it to a referral agency for processing and vice versa,

(3) Terms prohibiting the commission from processing a charge referred to and accepted by the referral agency and vice versa,

(4) Terms permitting the commission or a referral agency to reject a charge referred to it for processing,

(5) Terms ending the contract after two years, subject to renegotiation, and

(6) Any other terms mutually agreed upon.

1.6(4) *Procedure for obtaining deferral status.*

a. Application. Any agency desiring to be designated as a deferral agency by the commission may send a letter of application to the executive director of the commission. Attached to the application must be a copy of the agency's enabling legislation or grant of jurisdiction, a list of its personnel and statement indicating their permanent or part-time status, their functions, and a summary of the agency's prior efforts at preventing and eliminating discrimination. The application must also explain how the agency is capable of obtaining remedies substantially similar to those available under the Act.

b. Guidelines for designation. The executive director will evaluate the applications of all agencies and may designate deferral agencies where the agencies conform to the following guidelines:

(1) The agency should have available resources to enable it to investigate complaints to ensure processing within a reasonable period of time,

(2) The agency's enabling legislation or grant of jurisdiction must permit it to obtain substantially the same remedies as are available under the Act,

(3) The agency must be able to make a diligent effort to investigate and resolve the complaints filed with it, and

(4) The agency is capable of obtaining remedies substantially similar to those available under the Act by informal means.

c. Rejection of application. Where the executive director determines that an agency does not qualify as a deferral agency, the director shall so inform the agency in writing along with the reasons for the agency's rejection.

If the reasons for the agency's rejection are corrected, the agency will then be designated as a deferral agency. The executive director's decision may be appealed to the commission at its subsequent regular meeting.

d. Designation and contract. Where the executive director determines that an agency is qualified as a deferral agency, the director will prepare a contract between the commission and the agency

containing the terms on which cases will be deferred. After execution of the contract, the executive director will designate the agency as a deferral agency.

e. Terms of the deferral contract. The deferral contract shall include, subject to negotiations with the agency, the following:

(1) The commission will agree to notify the deferral agency of all complaints filed with the commission which are within the deferral agency's jurisdiction, except where a complainant requests in written form that the deferral agency not be notified.

(2) The deferral agency will agree to aid all complainants whose complaints come within the commission's jurisdiction in completing the commission's complaint forms as well as notarizing them and forwarding the fully executed forms to the commission where the necessity to file a formal complaint exists. If, however, a matter may be resolved informally more expeditiously the deferral agency will simply notify the commission by letter of the complaint and resolution obtained. "Informally resolved complaints" shall refer to complaints that can be resolved within ten days.

(3) The commission will agree to postpone its investigation for at least 60 days of any complaint filed with a deferral agency unless otherwise agreed to by both parties. These waiver agreements will be made on an individual case basis.

(4) The agency will agree not to disclose the filing of a complaint or confidential information pertaining to a complaint until the complaint has been officially set for public hearing.

(5) The commission and the deferral agency shall share copies of all findings, case summaries, and conciliation agreements.

(6) Where a complaint is on file with a deferral agency, the commission will allow the deferral agency access to the contents of the complainant's file provided that the deferral agency allows the commission like privileges and has not previously disclosed confidential information prior to public hearing.

(7) Photocopying of materials from commission files for use by a deferral agency is solely at the discretion of the commission staff, but will not be unreasonably denied. When the commission copies from the agency's file, the agency shall be reasonably compensated for copying costs.

(8) The commission will give substantial weight to the findings of a deferral agency where pertinent and relevant factual evidence exists to support those findings.

(9) The commission will not necessarily be bound by the agency's conclusions of law.

(10) Where a deferral agency reaches a finding of probable cause to support an allegation of discrimination the contract may permit the agency to pursue conciliation, or to refer the case back to the commission for conciliation. The contract may also permit an agency that has attempted conciliation to refer that case back to the commission for public hearing. In no case where a case has been referred back to the commission will it be referred back to the agency. Where a case is conciliated or a hearing is held by the agency or the commission, both will be bound by the final determination.

(11) The period for which the contract will be in effect shall not exceed two years, subject to renegotiation.

(12) The contract may contain other terms agreed to by the parties.

These rules are intended to implement Iowa Code chapter 216.

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[1] Effective date of 161—1.1(1)*"b,"* 1.5(7) and 1.5(8) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 1993; delayed until adjournment of the 1994 Session of the General Assembly by this Committee May 11, 1993.

CHAPTER 2
GENERAL DEFINITIONS

[Prior to 1/13/88, see Civil Rights 240—1.1(601A)]

161—2.1(216) Definitions.

2.1(1) Wherever "Act" is used in rules of the commission it shall mean the Iowa Civil Rights Act of 1965, as amended (Iowa Code chapter 216).

2.1(2) Unless indicated otherwise, the terms "court," "person," "employment agency," "labor organization," "employer," "employee," "unfair practice," or "discriminatory practice," "commission," "commissioner," and "public accommodation" shall have the same meaning as set forth in Iowa Code chapter 216.

2.1(3) The term "chairperson" shall mean the chairperson of the Iowa civil rights commission; and the term "commissioner" shall mean any member, including the chairperson, of the commission. The vice chairperson of the commission shall serve, in the absence of the chairperson, as acting chairperson; and, in the absence of the chairperson, the vice chairperson shall have all the duties, powers and authority conferred upon the chairperson by the Act and commission rules. At all times it shall be necessary that a quorum be present before the commission can transact any official business.

2.1(4) The term "complainant" shall mean the person, as defined in Iowa Code subsection 216.2(11), who makes a complaint of discrimination with the commission.

2.1(5) The term "executive director" shall mean an employee of the commission, selected by and serving at the will of the governor, who shall have the duties, powers and authority conferred upon the director by law.

2.1(6) Except as provided in paragraph *"b,"* the term "issuance" shall mean mailing by regular mail or, when required, U.S. certified mail, a document or letter indicating a decision or other administrative action of the commission. When certified mail is required, the date of issuance of a decision or an administrative action of the commission shall be the date the commission mails by U.S. certified mail a document or letter indicating the decision or action. When mailing is by regular mail, the date of mailing is presumed to be the date on the cover letter accompanying the administrative action or decision unless the date is shown to be in error.

a. Except as provided in paragraph *"b,"* the verb "issue" shall mean to mail by regular mail or, when required, by certified mail, a document or letter indicating a decision or other administrative action of the commission. When certified mail is required, the date an administrative action or decision is "issued" shall be the date the commission mails by U.S. certified mail a document or letter indicating the administrative decision or action. When mailing is by regular mail, the date of mailing is presumed to be the date on the cover letter accompanying the document or letter indicating the administrative decision or action, unless this date is shown to be in error.

b. When used to refer to a decision to administratively close a case, the term "issuance" and the verb "issue" can mean either the mailing of the document indicating administrative closure by regular mail or the mailing of that document by certified mail. The date an administrative closure is issued is the date the administrative closure is mailed to the complainant. When mailing is by regular mail, the date of mailing is presumed to be the date on the cover letter accompanying the administrative closure unless this date is shown to be in error. When certified mail is required, the date an administrative action or decision is "issued" shall be the date the commission mails by U.S. certified mail a document or letter indicating the decision or action.

c. When local mail is permissible, the date of mailing is presumed to be the date on the cover letter.

When used to refer to a subpoena, the term "issuance" and the verb "issue" shall each mean the signing of the subpoena by the issuing authority. The date a subpoena becomes effective is the date service is completed.

2.1(7) The term "respondent" shall mean the person, as that term is defined in Iowa Code subsection 216.2(11), against whom the complaint of discrimination is made with the commission.

2.1(8) The term "right to sue" shall mean the release issued by the commission stating that the complainant has a right to commence an action in the district court. The term "right to sue" is the same as the "release" or "administrative release" described in Iowa Code section 216.16 and these terms may be used interchangeably.

2.1(9) The term "verified" shall mean (a) sworn to or affirmed before a notary public, or other person duly authorized by law to administer oaths and take acknowledgments, or (b) supported by an unsworn declaration which recites that the person certifies the matter to be true under penalty of perjury, states the date of the statement's execution and is subscribed by the person. Such an unsworn declaration may be in substantially the following form: "I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct. Executed on (date). (Signature)."

2.1(10) Final actions. The following procedures shall constitute final actions of the commission:

a. The term "administratively closed" shall mean that the commission will cease action on a complaint because, in the opinion of the investigating official, no useful purpose would be served by further efforts. Administratively closing a case is appropriate in circumstances such as the following: The commission staff has not been successful in locating a complainant after diligent efforts; the respondent has gone out of business; a right-to-sue letter has been issued; or after a probable cause decision has been made, it is determined that the record does not justify proceeding to public hearing.

b. The term "no jurisdiction" shall mean that the alleged discriminatory act or practice is not one that is prohibited by the Act or where the complaint does not conform to the requirements of the Act.

c. The term "no probable cause finding" shall mean the procedure by which a complainant and respondent are notified that the investigating official has found that there is no probable cause to believe that discrimination exists after reviewing an investigation of a complaint.

d. The term "satisfactorily adjusted" shall mean that the complainant has indicated in writing that the complaint has been resolved to the satisfaction of the complainant, and that no further action is desired from the commission. Whenever the offer of adjustment by a respondent is acceptable to the investigating official, but not to the complainant, the commission may close the case as satisfactorily adjusted. In a case which has been determined by the commission as having probable cause, the respondent's signature must be obtained before the case can be considered to be satisfactorily adjusted.

e. The term "successfully conciliated" shall mean that a written agreement has been executed on behalf of the respondent, on behalf of the complainant, and on behalf of the commission, the contents of which are designed to remedy that alleged discriminatory act or practice and any other unlawful discrimination which may have been uncovered during the course of the investigation.

f. The term "withdrawn" shall mean that a complainant has indicated in writing the desire that no further action be taken by the commission regarding the complaint.

2.1(11) Construction of rules. The rules and regulations promulgated by the Iowa civil rights commission shall be liberally construed to effectuate the purposes and provisions of Iowa Code chapter 216.

2.1(12) The term "terms and conditions of employment," shall include but is not limited to medical, hospital, accident and life insurance or benefits, leave, vacations, and other terms, conditions, and privileges of employment.

[1]**2.1(13)** The term "injury" shall mean a loss of pecuniary benefit, rights, or any offense against a person's dignity.

2.1(14) The term "certified mail" shall mean delivery by United States Postal Service mail designated as certified mail.

2.1(15) The term "local mail" shall mean Iowa state government local (interoffice) delivery. Local mail is sent and delivered between state government offices in an envelope designated "Local," without the need for postage.

2.1(16) The term "mail or regular mail" shall mean delivery by United States Postal Service mail delivered at regular speed or delivery by courier service.

2.1(17) The term "electronic filing" shall mean submission of documents via the online case management system established and utilized by the commission or via another online system. The commission may require proof to ensure the accuracy and validity of online filings, including additional

written verification of the veracity and accuracy of documents filed online. Senders shall include in the subject line of the E-mail the case number, if one exists, and a brief description of the submission. Filings by E-mail must be delivered to a valid E-mail address of current commission staff.

2.1(18) The term "electronic signature" shall mean that a person attests to the validity of the electronic documents. Electronic signatures accompany various forms of electronic submissions including, but not limited to, E-mails and submissions made online through the case management system. The commission may permit and accept electronic signatures in E-mails, depending on the type of document. An electronic signature in the case management system consists of a person's name typed and submitted into the designated field.

2.1(19) The terms "written" and "in writing" shall mean the creation of words, phrases, or sentences by any means including, but not limited to, pen and paper, typewriter text, computer discs, computer text, electronic text and any other medium.

[**ARC 8746B**, IAB 5/5/10, effective 6/9/10; **ARC 8748B**, IAB 5/5/10, effective 6/9/10; **ARC 8747B**, IAB 5/5/10, effective 6/9/10]

[1] Objection to 2.1(8) [Prior to 1/13/88 numbered as 1.1(9)] reimposed by ARRC 4/20/88, republished 5/4/88, see full text of objection on following page.

These rules are intended to implement Iowa Code chapter 216.

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[1] The Administrative Rules Review Committee at its May 21, 1979, meeting delayed the effective date of 240—subrules 1.1(7) to 1.1(9), 1.3(1), 1.8(2) and rules 1.16 and 1.17 70 days.

[2] The Administrative Rules Review Committee at its February 11, 1988, meeting delayed the effective date of subrule 2.1(8) 70 days.

[3] Effective date of 161—2.1(4), 2.1(6) to 2.1(11) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 1993; delayed until adjournment of the 1994 Session of the General Assembly by this Committee May 11, 1993.

On July 11th, 1979, the administrative rules review committee voted the following objections:

The committee objects to ARC 0192, item 1, appearing in Vol. 1, IAB 23 (4-18-79), relating to the definition of terms, on the grounds these provisions are beyond the authority of the commission and unreasonable. Specifically, the committee is concerned with subrules 1.1(8) and 1.1(9) appearing under item 1. Subrule 1.1(8) provides:

The term "retirement plan and benefit system" as used in section 601A.12 of the Code relates only to the discontinuation of employment pursuant to the provisions of such retirement plan or system. A retirement plan or benefit system shall be limited to those plans or systems where contributions are limited to those plans or systems where contributions are based upon anticipated financial costs of the needs of the retiree.

It is the opinion of the committee this subrule exceeds the authority of the commission in that it is an overbroad interpretation of §601A.13, the Code. That section in essence exempts from the provisions of the Act retirement plans or benefit systems which discriminate on the basis of age or sex, unless the plan is a "mere subterfuge". The exemption does not appear limited to plans or systems "relating only to the discontinuation of employment" or those "where contributions are based upon the anticipated financial costs of the retiree" as the subrule provides. Under the subrule, a plan or system which fails to meet either of the above criteria would apparently automatically be considered unfair discrimination. If the General Assembly had intended this result it would have so provided within the Act.

It is further the opinion of the committee subrule *1.1(9) defining as "injury", for which damages may be awarded, an offense against a person's dignity, is unreasonable in that it provides no ascertainable standard to determine what damage the offended party has suffered. Under the provisions of §601A.15(8)*"a"*(8) the commission clearly has the authority to award damages for an injury. The committee believes this term to mean that the party has been harmed in some way that damage received can be measured and appropriate recompense awarded for that damage. Dignity, like beauty, is in the eye of the beholder. Absent a showing that physiological or psychological damage has resulted from an "offense against a person's dignity", it appears impossible to accurately measure the financial equivalent of such an injury or to award appropriate damages.

*Renumbered as 2.1(8), IAC 1/13/88; 2.1(8) renumbered as 2.1(13), IAC 2/17/93.
Note: Iowa Code chapter 601A renumbered as chapter 216 in 1993 Iowa Code.

CHAPTER 3
COMPLAINT PROCESS

[Prior to 1/13/88, see Civil Rights 240—1.3 to 1.7, 1.16, 1.17]

161—3.1(216) Anonymity of complaint. For purposes of public commission meetings the complaints shall be identified only by case number so that the anonymity of the complaints and parties can be preserved. Nothing in this provision shall apply to executive sessions of the commission or meetings after the commission has made a decision to hold a public hearing.

161—3.2(216) Access to file information. The disclosure of information, whether a charge has been filed or not, or revealing the contents of any file is prohibited except in the following circumstances:

3.2(1) If a final decision per 161—subrule 2.1(10) has been reached, a party or a party's attorney may, upon showing that a petition appealing the commission action has been filed, have access to the commission's case file on that complaint.

3.2(2) If a case has been approved for public hearing and the letter informing parties of this fact has been mailed, any party or party's attorney may have access to file information through prehearing discovery measures provided in 161—subrule 4.2(2).

3.2(3) If a decision rendered by the commission in a contested case has been appealed, any party or party's attorney may, upon showing that the decision has been appealed, have access to the commission's case file on that complaint.

The fact that copies of documents related to or gathered during an investigation of a complaint are introduced as evidence during the course of a contested case proceeding does not affect the confidential status of all other documents within the file which are not introduced as evidence.

3.2(4) If the commission has issued a right-to-sue letter per subrule 3.9(3), a party or party's attorney may have access to the commission's case file on that complaint.

3.2(5) Only upon written notification from an attorney or a party that the attorney represents may the attorney then obtain access to the commission case file on the same terms as that party.

161—3.3(216) Timely filing of the complaint.

3.3(1) *Limitation.* The complaint shall be filed within the 300 days after the occurrence of an alleged unlawful practice or act.

3.3(2) *Continuing violation.* If the alleged unlawful discriminatory practice or act is of a continuing nature, the date of the occurrence of the alleged unlawful practice shall be deemed to be any date subsequent to the commencement of the alleged unlawful practice up to and including the date upon which the unlawful practice has ceased.

3.3(3) *Tolling of filing period.* By law the filing period described in subrule 3.3(1) and in Iowa Code subsection 216.15(12) is subject to waiver, estoppel and equitable tolling. Whether the filing period shall be equitably tolled in favor of a complainant depends upon the facts and circumstances of the particular case. Equitable tolling suspends the running of the filing period during the period of time in which the grounds for equitable tolling exist.

[**ARC 8744B**, IAB 5/5/10, effective 6/9/10]

161—3.4(216) Complaints.

3.4(1) *Filing complaint.* Any person claiming to be aggrieved by a discriminatory or unfair practice may, personally or by an attorney, make, sign, and file with the commission a verified, written complaint. The attorney general, the commission, or a commissioner may initiate the complaint process by filing a complaint with the commission in the same manner as an aggrieved person.

3.4(2) *Contents of complaint.* Each complaint of discrimination should contain the following:

a. The full name, address and telephone number, if any, of the person making the charge;

b. The full name and address of each respondent;

c. A clear and concise statement of the facts, including pertinent dates, if known, constituting each alleged unfair or discriminatory practice;

d. If known and if employment discrimination is alleged, the approximate number of employees of a respondent employer.

3.4(3) *Technical defects in complaint.* Notwithstanding the provisions of subrule 3.4(2), a complaint is sufficient when the commission receives from the complainant a written statement sufficiently precise to identify the parties and to describe generally the action or practices complained of. A complaint may be amended to cure technical defects or omissions, including failure to verify the complaint. Such amendments will relate back to the date the complaint was filed.

161—3.5(216) Filing of documents with the Iowa civil rights commission.

3.5(1) *Methods of filing.* Any document, including a complaint of discrimination, may be "filed" with the commission by any one of the following methods:

a. In person. By delivery in person to the offices of the commission at the location set forth in 161—paragraph 1.1(1)*"b"* during the office hours set forth in said paragraph *"b."*

b. By mail or regular mail. By depositing the document in the United States mail, or sending it by courier service, postage prepaid, in an envelope addressed to the Iowa civil rights commission at the address set forth in 161—paragraph 1.1(1)*"b."* In the case of state agencies or other persons served by the Iowa state government local (interoffice) mail, it is sufficient to deposit the document in Iowa state government local (interoffice) mail in an envelope designated "Local" and addressed to the "Iowa Civil Rights Commission."

c. By facsimile transmission (fax). By transmitting via facsimile transmission a copy of the document to the fax number set forth in 161—paragraph 1.1(1)*"b."*

A document filed by fax is presumed to be an accurate reproduction of the original. If a document filed by fax is illegible, a legible copy shall be substituted and the date of filing shall be the date the illegible copy was received.

d. By courier service. By delivering the document to an established courier service for immediate delivery to the Iowa civil rights commission at the address set forth in 161—paragraph 1.1(1)*"b."*

e. By certified mail. By sending the document in the United States mail designated as certified mail.

f. By local mail. By depositing the document in Iowa state government local (interoffice) mail in an envelope designated "Local" and addressed to the "Iowa Civil Rights Commission."

g. By case management system. By submitting a document online via the case management system. The documents which may be filed online via the case management system are set at the discretion of the commission. Complainants and respondents filing paper documents may, when authorized by the commission, use electronic filing for those documents the commission permits to be submitted online through the case management system.

h. By E-mail. By attaching a document to or sending a document within the body of an E-mail. The commission shall have discretion over which documents may be filed by E-mail. Official signature requirements may vary from one type of document to another and shall be determined at the discretion of the commission. The commission may establish procedures to ensure the accuracy and validity of online filings and to notify parties of the receipt of electronic filings. Filings by E-mail must be delivered to a valid E-mail address of current commission staff designated to accept filed documents. The commission may require additional written verification of the veracity and accuracy of documents filed online. Senders shall include in the subject line of the E-mail the case number, if one exists, and a brief description of the submission.

3.5(2) *Suggested procedures for facsimile transmissions (fax).* In order to avoid an incomplete or illegible fax, it is suggested that those desiring to "file" a document via that method follow these procedures:

a. Precede each transmission with a cover sheet setting forth the name of the sender, the specific individual (if any) to whom the transmission is directed, the date of the transmission, and the number of pages including the cover sheet to be transmitted.

b. On the same day as the transmission, speak by telephone to a member of the staff of the commission and confirm that the transmission was received and all pages were legible.

c. After the transmission, promptly mail to the commission the original "hard copy" of the document along with the cover sheet which preceded the transmission (or a copy of the transmission report).

d. After the transmission, mail to the commission a letter setting forth the date and time of the transmission and, if applicable, the specific individual to whom the sender spoke in order to confirm that the transmission was received and all pages were legible.

3.5(3) *Charge for facsimile transmissions in excess of five pages.* For facsimile transmissions in excess of five pages, the commission may bill the sender a reasonable fee for each page in excess of five pages.

3.5(4) *Date a document is deemed to be "filed" with the commission.* The date on which any document is deemed to be "filed" with the commission is determined according to the following:

a. Filing in person. If the document, including a complaint of discrimination, is filed in person as set forth in paragraph 3.5(1)*"a,"* then the date of the filing is the date that the document is delivered to the commission offices and date-stamped received.

b. Filing by mail or regular mail. If the document, except for a complaint of discrimination, is filed by mail or regular mail as set forth in paragraph 3.5(1)*"b,"* then the date of the filing is the date of mailing.

c. Filing by facsimile transmission. If the document, including a complaint of discrimination, is filed by facsimile transmission as set forth in paragraph 3.5(1)*"c,"* the date of the filing is the date the document is received by the commission as shown on the face of the facsimile. However, if a transmission is received after the office hours set forth in 161—paragraph 1.1(1)*"b,"* the date of filing is the next day the commission offices are open for business. Transmissions received prior to office hours on a regular business day are deemed filed on that day.

d. Filing by courier service. If the document, except for a complaint of discrimination, is filed by courier service as set forth in paragraph 3.5(1)*"d,"* then the date of the filing is the date the document is delivered to the established courier service for immediate delivery to the Iowa civil rights commission at the address set forth in 161—paragraph 1.1(1)*"b."*

e. Filing online via case management system. If a document, including a complaint of discrimination, is filed online via the case management system as set forth in paragraph 3.5(1)*"g,"* the date of the filing is the date that document is received by the commission as recorded in the case management system. However, if the submission is received after the office hours set forth in 161—paragraph 1.1(1)*"b,"* the date of filing is the next day the commission offices are open for business. A submission received prior to office hours on a regular business day is deemed filed on that day.

f. Filing online through E-mail. If a document, including a complaint of discrimination, is filed online via E-mail, as set forth in paragraph 3.5(1)*"h,"* the date of the filing is the date that document is received by the commission as recorded in the E-mail inbox of the commission staff person. However, if the submission is received after the office hours set forth in 161—paragraph 1.1(1)*"b,"* the date of filing is the next day the commission offices are open for business. A submission received prior to office hours on a regular business day is deemed filed on that day.

g. Presence of commission receipt stamp. Except where the date of the receipt stamp is demonstrated to be in error, the date of filing of a document, including a complaint of discrimination, shall in no event be deemed to be later than the date shown by the dated commission receipt stamp on the document. Complaints filed online via the case management system shall receive an online record of the date and time filed, and the online record shall be considered the dated commission receipt stamp.

3.5(5) *Proof of mailing.* Adequate proof of the date of mailing includes the following:

a. A legible United States Postal Service postmark on the envelope in which the document was enclosed.

b. A legible postage meter mark on the envelope in which the document was enclosed.

c. The date disclosed on a certificate of service.

d. The date disclosed on a notarized affidavit of mailing.

e. The date disclosed on a certification in substantially the following form: "The undersigned certifies under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing) I mailed copies of (describe document) addressed to the Iowa Civil Rights Commission, 400 E. 14th Street, Des Moines, Iowa 50319, and to the names and addresses of the persons listed below by depositing a copy thereof (in a United States post office mailbox with correct postage properly affixed) or (state interoffice mail) (Date) (Signature)."

f. The date listed on the cover letter which was sent by regular mail.

3.5(6) *Conflict among proofs of mailing.* The date of mailing is the date shown by the postmark. In the absence of a legible postmark, the date of mailing is the date shown by the postage meter mark, and only in the absence of both a legible postmark and a legible postage meter mark, the date of mailing is the date shown by the affidavit, certificate, or certification of mailing.

3.5(7) *Filing of complaint.*

a. A complaint of discrimination is filed by any of the methods listed in this rule.

b. The date a complaint of discrimination is filed with the commission is the date the complaint is received by the commission. However, if the complaint is filed by fax or online via the case management system or E-mail and is received after the office hours set forth in 161—paragraph 1.1(1)*"b,"* the date of filing is the next day the commission offices are open for business. Transmissions or submissions or other online filings received prior to office hours on a regular business day of the commission are deemed filed on that day.

c. Except where the date of the receipt stamp is demonstrated to be in error, the date of filing of a complaint of discrimination shall in no event be deemed to be later than the date shown by the dated commission receipt stamp on the complaint. Complaints filed online via the case management system shall receive an online record of the date and time filed, which shall be considered the dated commission receipt stamp.

[**ARC 8743B**, IAB 5/5/10, effective 6/9/10]

161—3.6(216) Notice of the complaint. After jurisdictional review and within 20 days of receipt of the complaint, the commission will serve a complaint on a respondent by regular or electronic mail. If the first named respondent does not respond to the service by regular or electronic mail after 90 days, the commission shall serve the complaint on the first named respondent by certified mail within 20 days after the expiration of the 90-day response period. A letter of acknowledgment shall advise the complainant of the right to withdraw the complaint and sue in the appropriate district court according to Iowa Code section 216.16.

[**ARC 8743B**, IAB 5/5/10, effective 6/9/10]

161—3.7(216) Preservation of records.

3.7(1) *Employment records.* When a complaint or notice of investigation has been served on an employer, labor organization or employment agency under the Act, the respondent shall preserve all records relevant to the investigation until the complaint or investigation is finally adjudicated. The term "relevant to the investigation" shall include, but not be limited to, personnel, employment or membership records relating to the complainant and to all other employees, applicants or members holding or seeking positions similar to that held or sought by the complainant, and application forms or test papers completed by any unsuccessful applicant and by all other applicants or candidates for the same position or membership as that for which the complainant applied and was not accepted, and any records which are relevant to the scope of the investigation as defined in the notice or complaint.

3.7(2) *Other records.* Any books, papers, documents, or records of any form which are relevant to the scope of any investigation as defined in the notice or complaint shall be preserved during the pendency of any proceedings by all parties to the proceedings unless the commission specifically orders otherwise.

3.7(3) *Adverse inference.* If after a public hearing the administrative law judge determines:

a. That a party or agent, employee, or person acting for the party has destroyed evidence in violation of subrule 3.7(1) or 3.7(2), and

b. That the destruction was done at a time when the party knew or should have known that the evidence destroyed was relevant to the investigation, and

c. There is no satisfactory explanation for the destruction of the evidence, then the administrative law judge may infer that the destroyed evidence was adverse to the party who destroyed the evidence or whose agent or employee destroyed the evidence or on behalf of whom any other person was acting when destroying the evidence.

161—3.8(216) The complaint.

3.8(1) *Amendment of complaint.*

a. A complaint or any part may be amended by the complainant or by the commission anytime prior to the hearing thereon and, thereafter, at the discretion of the administrative law judge. The complaint may be amended to include additional material allegations the investigation may have disclosed.

To prevent unnecessary litigation or duplication, the commission may amend a complaint based upon information gained during the course of the investigation. The scope of the issues at public hearing shall include the facts as uncovered in the investigation and shall not be limited to the allegations as stated in the original complaint. Provided, however, that when an amendment is made, the respondent may be granted a continuance within the discretion of the administrative law judge if it is needed to allow the respondent to prepare to defend on the additional grounds.

b. Amendments alleging additional acts which constitute unfair or discriminatory practices related to or growing out of the subject matter of the original complaint will relate back to the date the original complaint was filed. If a reasonable investigation of the initial complaint would encompass an alleged unfair or discriminatory practice then that alleged unfair or discriminatory practice grows out of the subject matter of the original complaint.

c. Amendments alleging additional acts which constitute unfair or discriminatory practices which are not related to and which do not grow out of the subject matter of the original complaint will be permitted only where at the date of the amendment the allegation could have been filed as a separate complaint. The complaint as so amended shall then be processed by the commission as a single complaint of discrimination.

3.8(2) *Amendments adding those allegedly liable as successors and relation back.* Whenever the commission or complainant learns subsequent to the filing of the original complaint that an entity may be liable as a successor to the respondent named in the original complaint, the complainant or the commission may at any time amend the complaint to add the alleged successor as a respondent. Provided, however, that when such an amendment is made after issuance of the notice of hearing the alleged successor added by the amendment may be granted a continuance within the discretion of the administrative law judge, if it is needed to allow the alleged successor to prepare its defense. An amendment adding an alleged successor always relates back to the date of the filing of the original complaint.

3.8(3) *Withdrawal of complaint.* A complaint or any part thereof may be withdrawn by the complainant at any time prior to the hearing thereon and, thereafter, at the discretion of the commissioners. However, nothing herein shall preclude the commission from continuing the investigation and initiating a complaint on its own behalf against the original respondent, as provided for in the Act, whenever it deems it in the public interest.

161—3.9(216) Jurisdictional review. Upon the receipt of a statement offered as a complaint, the executive director or designee shall review the complaint to determine whether the commission has jurisdiction of the complaint. A no jurisdiction determination shall constitute final agency action for purposes of judicial review.

161—3.10(216) Right to sue.

3.10(1) *Request for right to sue.* After the expiration of 60 days from the timely filing of a complaint with the commission, the complainant may request a letter granting the complainant the right to sue for relief in the state district court.

3.10(2) *Conditions precedent to right to sue.* Upon a request under subrule 3.10(1), the commission shall mail to the complainant a right-to-sue letter where the following conditions have been met.

a. The complaint was filed with the commission as provided in rule 161—3.5(216);

b. The complaint has been on file with the commission for at least 60 days;

c. The right-to-sue request has been submitted in writing with the signature of the complainant or the complainant's representative, unless otherwise prohibited by state or federal rules or contractual agreements. Electronic signatures are permissible for right-to-sue requests;

d. The date of request is listed as well as the corresponding state and federal case numbers.

3.10(3) *Letter of right to sue.* Where the above conditions have been met, a right-to-sue letter will be mailed stating that complainant has a right to commence an action in the state district court within 90 days of the date of mailing of the right-to-sue letter.

3.10(4) *Exceptions to issuance of right to sue.* Notwithstanding the provisions of any other rule a right-to-sue letter shall not be sent if on the date the request for a right to sue was filed any of the following is true:

a. A finding of "no probable cause" has been made on the complaint by the administrative law judge charged with that duty under Iowa Code subsection 216.15(3); or

b. A conciliation agreement has been executed under Iowa Code section 216.15; or

c. The commission has served notice of hearing upon the respondent pursuant to Iowa Code subsection 216.15(5); or

d. The complaint has been administratively closed and two years have elapsed since the issuance date of the administrative closure; or

e. A finding that the complaint was not timely filed has been made by the commission pursuant to rule 161—3.9(216) or by the administrative law judge charged with the duty of determining "probable cause" under Iowa Code subsection 216.15(3); or

f. A finding that the commission does not have jurisdiction of the complaint has been made pursuant to rule 161—3.9(216) or by the administrative law judge charged with the duty of determining "probable cause" under Iowa Code subsection 216.15(3).

3.10(5) *Closure by commission.* When the commission has sent a right-to-sue letter, a commission staff member shall close the case by an administrative closure. Notice of the closure shall be mailed to all parties.

[**ARC 8742B**, IAB 5/5/10, effective 6/9/10]

161—3.11(216) Mediation.

3.11(1) Mediation shall be available once a complaint has been filed, when a party to the complaint requests mediation, when the case has been preliminarily screened in for investigation pursuant to the procedures set forth in rule 161—3.12(216), or at any time while the complaint is still open and the parties agree to participate. Mediation is a neutral, non-fact-finding process, at which parties attempt to negotiate a no-fault predetermination settlement for the purpose of amicably resolving the complaint. Mediation shall be available to all parties irrespective of representation by counsel. Mediation may encompass all issues in the case which could have been investigated by the commission including any claims for unlawful retaliation that may exist through the date of the mediation notice. If the parties agree to seek and obtain a global settlement not limited to a resolution of the civil rights issues, the mediation may be expanded to include these collateral claims.

3.11(2) Mediation notification shall be sent via regular or electronic mail to all parties and their respective counsels, if applicable. Notification may include detailed information on the mediation process.

[**ARC 8741B**, IAB 5/5/10, effective 6/9/10]

161—3.12(216) Administrative review and closure.

3.12(1) *Preliminary screening.*

a. Questionnaire. As soon as practicable after receipt of a complaint, the commission may draft and mail to the parties written questionnaires. Respondent and complainant may respond via regular, certified or local mail, electronic mail, or online via the commission's case management system. Complainant and respondent will receive different sets of questions as the complainant and respondent typically have different items of information and different interpretations of the facts. The questionnaire will be as specific as practicable to the particular complaint.

b. Responses to the questionnaire.

(1) Respondent and complainant are required to respond in writing to their respective questionnaires. The answers ordinarily should be responsive to the questions asked, though elaboration is encouraged. If a question does not apply, the responder can so indicate. In lieu of answers responsive to the particular questions, the commission will accept written position statements, provided the statements respond to the allegations. The position statements should cover the same general subject areas covered by the questionnaire. Accompanying supportive evidence is required, including application materials, job descriptions, organizational charts, selection procedures, policies, procedures, employee handbooks, job descriptions, signed statements from witnesses, performance evaluations, discipline records, E-mails, photographs, internal investigation records, and other documents that are relevant. The documents should encompass how the complainant was treated and how persons similarly situated to the complainant were treated.

(2) Responses are due 30 days from the mailing of the questionnaire. Extensions will be granted on an informal basis. Requests for extensions may be oral and may be granted or denied orally. No notice of the request for an extension or of the disposition of that request need be given to the nonrequesting party. A requesting party may assume the extension is approved unless otherwise notified. Requests for extensions may be granted for 30 days or less. Extensions greater than 30 days may be subject to review by the executive director or designee. The legislature encourages preliminary screening to be completed within 120 days of the filing of the complaint; therefore, requests for extensions are strongly discouraged. A request for an extension by a party shall constitute a waiver by that party of any objection to the commission taking longer than the 120-day period to screen the complaint.

c. Failure to respond.

(1) Complainant. A complaint may be administratively closed when a complainant fails to respond to the questionnaire.

(2) Respondent. A complaint may be screened in and assigned to investigation when a respondent fails to respond to the questionnaire. Also, information may be sought pursuant to the commission's subpoena procedures.

d. Suggested procedure in answering questionnaire. Answers should be as clear and as precise as possible. Answers too long to be placed on the questionnaire itself should be numbered by part and question number and placed on a separate sheet. The parties are encouraged to submit as much supporting documentation as possible including affidavits of witnesses and documentation of treatment of individuals comparable to the complainant. Where not readily apparent, the significance of the submitted supporting documentation should be explained. This may be done through an answer that refers the commission to a particular item of the submitted supporting documentation.

e. Preliminary screening process. As soon as practicable after the receipt of all materials responsive to the questionnaires, the executive director or designee shall review the submitted answers and materials. The executive director or designee shall then determine whether the case will be "screened in" as warranting further processing or "screened out" as not warranting further investigation.

f. Standard for screening. A case will be screened in when further processing is warranted. Further processing is warranted when the collected information indicates a reasonable possibility of a probable cause determination or the legal issues in the complaint need development.

g. Effect of screen out. A complaint determined not to warrant further processing shall be administratively closed.

h. Effect of failure to follow screening procedure. Preliminary screening is a tool to remove from the commission's active complaints those cases which the collected preliminary information indicates do not warrant further processing. Irregularities in the preliminary screening of a complaint, failure to complete preliminary screening within 120 days of the filing of the complaint, or failure to follow the preliminary screening procedure altogether shall not, by itself, in any way prejudice the rights of either party.

3.12(2) *Periodic review and administrative closure.*

a. Periodic evaluation of evidence. The executive director or designee may periodically review the complaint to determine whether further processing is warranted. Where the periodic review occurs prior to the determination of whether there is probable cause, then processing is warranted when the collected information indicates a reasonable possibility of a probable cause determination or the legal issues in the complaint need development. A complaint determined not to warrant further processing shall be administratively closed.

b. Uncooperative complainant. A complaint may be administratively closed at any time if the complainant cannot be contacted after diligent efforts or is uncooperative, causing unreasonable delay in the processing of the complaint.

c. Involuntary satisfactory adjustment. A complaint may be closed as satisfactorily adjusted when the respondent has made an offer of adjustment acceptable to the executive director or designee but not to the complainant. Notice of intended closure shall state reasons for closure and shall be mailed to the complainant. The complainant shall be allowed 30 days to respond. The response shall be in writing and state the reasons why the complaint should remain open. The executive director or designee shall review and consider the response before making a closure decision.

d. Litigation review. The complaint may be administratively closed after a probable cause determination has been made where it is determined that the record does not justify proceeding to public hearing.

3.12(3) *Purpose and effect of administrative closures.* An administrative closure need not be made as a result of the procedures governing a determination of whether there is probable cause. Unlike a "no probable cause determination" an administrative closure is not a final determination of the merits of the case. An administrative closure resulting from preliminary screening is merely an estimation of the probable merits of the case based on the experience and expertise of the commission. An administrative closure does not have the same effect as a determination of "no probable cause."

[**ARC 8740B**, IAB 5/5/10, effective 6/9/10; **ARC 8739B**, IAB 5/5/10, effective 6/9/10]

161—3.13(216) Investigation. The executive director or designee shall make a prompt investigation of the complaint. The administrative law judge may participate in the investigation and may direct the investigation. The investigator shall make a recommendation to the administrative law judge. The administrative law judge shall review the recommendation and issue a determination of probable cause or no probable cause for the commission.

3.13(1) *Cause determinations.* After a complaint has been filed, the executive director or a designated staff member shall assign a member of the investigatory staff to make a prompt investigation of the complaint. The investigator may confer with, be assisted by, or be directed by the administrative law judge during the investigation. The administrative law judge may participate in the investigation and engage in ex parte communications with the parties or their counsel. The investigator shall review all of the evidence and make a recommendation of probable cause or no probable cause or other appropriate action to the administrative law judge designated to issue findings. The administrative law judge shall review the case file and issue a determination of probable cause or no probable cause or other appropriate action on behalf of the commission.

3.13(2) *Rejection of investigator's recommendation.* Where the administrative law judge rejects the recommendation of the staff, the reasons shall be stated in writing and placed in the case file.

3.13(3) *Notice of decision.* Both the complainant and respondent may be notified of the decision in writing by regular or certified mail within 15 days of the administrative law judge's decision.

3.13(4) *Conflicts prohibited.* The administrative law judge designated to issue a finding shall not be permitted to serve as administrative law judge in a contested case where that administrative law judge has issued a finding in the same case.

3.13(5) *Administrative closure and satisfactory adjustments.* Designated staff of the commission may rule that a case be "administratively closed" as defined in 161—paragraph 2.1(10)*"a,"* where no useful purpose would be served by further action by the commission, such as where the complainant has not been located after diligent efforts, issuance of a right-to-sue letter, or where, after a probable cause decision has been made, it is determined that the record does not justify proceeding to public hearing. Designated staff of the commission may close a case as "satisfactorily adjusted" as defined in 161—paragraph 2.1(10)*"d."* This provision does not contemplate administrative closure where an alternative resolution, such as full investigation, is warranted.

3.13(6) *Conciliation.* All cases that result in findings of probable cause shall be assigned to a staff conciliator for the purpose of initiating attempts to eliminate the discriminatory or unfair practice by conference, conciliation, or persuasion. When a conference is held, a synopsis of the facts which led to the finding of probable cause along with written recommendations for resolution will be presented to the respondent.

3.13(7) *Participants.* Both the complainant and respondent shall be notified in writing of the time, date, and location of any conciliation meeting. The complainant may be present during attempts at conciliation.

3.13(8) *Minimum period for conciliation attempts.* Upon the commencement of conciliation efforts, the commission must allow at least 30 days for the parties to reach an agreement. Conciliation efforts may be conducted by mail, teleconferencing, or face-to-face meetings with the parties at the discretion of the commission. The mandatory 30-day period for conciliation begins when the complainant and the commission's offer of settlement is communicated to respondent or respondent's attorney. After the passage of 30 days the executive director may order further conciliation attempts bypassed if it is determined that the procedure is unworkable. The director must have the approval of a commissioner before bypassing conciliation.

3.13(9) *Conciliation agreements.* A conciliation agreement shall become effective after it has been signed by the respondent or authorized representative, by the complainant or authorized representative, and by either a commissioner, the executive director or designee on behalf of the commission. Copies of the agreement shall be mailed to all parties.

3.13(10) *Breach of conciliation agreement.*

a. At any time in its discretion the commission may investigate whether the terms of a conciliation agreement are being complied with by the respondent. Upon a finding that the terms of the conciliation agreement are not being complied with by the respondent, the commission shall take appropriate action to ensure compliance.

b. Enforcement in court. Appropriate action to ensure compliance as used in the preceding paragraph includes the filing of an action in district court seeking specific performance of the terms of the conciliation agreement or other remedies which may be available.

[**ARC 8738B**, IAB 5/5/10, effective 6/9/10]

161—3.14(216) Investigative subpoenas.

3.14(1) *Application of rule.* The provisions of rule 161—3.13(216) apply to subpoenas served prior to the issuance of the notice of hearing described in rule 161—4.1(216).

3.14(2) *Prior to notice of hearing.* The executive director, or designee, may issue subpoenas prior to the issuance of a notice of hearing. Neither the complainant, except when the commission is acting as the complainant, nor the respondent shall have the right to demand that a subpoena be issued.

3.14(3) *Initial information request.* Before a subpoena is sought to determine whether the agency should institute a contested case proceeding, the commission staff shall make a request in written form of the person having possession, custody, or control of the requested material or real evidence. The written request shall be either hand delivered by a member of the commission staff or sent by certified mail, return receipt requested. Where a person fails to provide requested information a subpoena may be

issued. A subpoena may be issued not less than seven days after the written request has been delivered to the person having possession, custody, or control of the requested materials.

3.14(4) *Form of subpoena.* Every subpoena shall state the name of the commission and the purpose for which the subpoena is issued.

3.14(5) *To whom directed.* The subpoena shall be directed to a specific person, or the person's attorney, or an officer, partner, or managing agent of any person who is not a natural person. If the person having possession, custody, or control of the requested material is unknown, the subpoena may be directed to the "custodian of records" for the person who is known to have possession, custody, or control of the requested material or real evidence. The subpoena shall command the person to whom it is directed to produce designated books, papers, or other real evidence in the possession, custody, or control of that person at a specified time and place. Where a public hearing has been scheduled, the subpoena may command the person to whom it is directed to attend and give testimony.

3.14(6) *Method of service.* The subpoena shall be served either by personal service by an official authorized by law to serve subpoenas or by any member of the commission staff by delivery of a copy to the person named therein. Service which is accomplished in accord with the Iowa Rules of Civil Procedure governing personal service is sufficient for the purpose of service of subpoenas under these rules.

3.14(7) *Proof of service.* Where service is accomplished by personal service, proof of service will be by acknowledgment of receipt by the person served or by the affidavit of the person serving the subpoena. Failure to make proof of service shall not affect the validity of the service.

3.14(8) *Objections to subpoena.*

a. Any person who intends not to comply with all or part of a subpoena issued by the commission shall promptly petition the executive director to revoke or modify the subpoena. The petition shall separately identify each portion of the subpoena with which the petitioner does not intend to comply and shall state, with respect to each such portion, the grounds upon which the petitioner relies. A copy of the subpoena shall be attached to the petition. The executive director or designee may as soon as practicable make a final determination upon the petition. The commission shall then mail the determination of the petition by regular mail to the petitioner.

b. In general, the grounds for modification or revocation of a subpoena are:

(1) The subpoena is not within the statutory authority of the commission;

(2) The subpoena is not reasonably specific;

(3) The subpoena is unduly burdensome;

(4) The subpoena is not reasonably relevant to matters under investigation.

c. To ensure prompt processing of a petition to revoke or modify a subpoena such a petition should be captioned "Motion to Quash" or "Petition to Modify/Revoke Subpoena" or some substantially similar title. The case number assigned to the case should appear on the petition. The petition should be directed to the attention of the executive director of the commission.

3.14(9) *Failure to comply.* Where a person fails to comply with a subpoena, the executive director or designee may authorize the filing of a petition for enforcement in the district court.

3.14(10) *Open public records law.* The inclusion of a record as a confidential public record under Iowa Code chapter 22 does not in any way affect the authority of the commission to subpoena and compel the production of that record. Iowa Code chapter 22 does not govern or affect the access by the commission to public records through its subpoena power.

[**ARC 8745B**, IAB 5/5/10, effective 6/9/10]

161—3.15(216) Injunctions. If the executive director or an appropriately designated staff person determines that a complainant may be irreparably injured before a public hearing can be called to determine the merits of the complaint, the executive director or designee may instruct an attorney for the commission to seek injunctive relief as may be appropriate to preserve the rights of the complainant and the public interest.

161—3.16(216) Procedure to reopen.

3.16(1) *Application of rule.* The provisions of this rule apply only to commission decisions and actions taken prior to the issuance of the notice of hearing described in rule 161—4.1(216).

3.16(2) *Reopening by commission—general rule.*

a. At any time during which the commission would be required to issue a right-to-sue letter if the complainant were to request one, the commission may, in its discretion, reopen and reconsider any administrative closure of the commission.

b. The parties shall be notified whenever the commission is considering the reopening of a matter closed by an "administrative closure," which notification shall include the reasons therefor. The parties shall be afforded no less than 14 and no more than 30 days to submit their positions, in writing, on the reopening.

c. The commission may reopen and reconsider an administrative closure where the commission finds that the administrative closure was substantially influenced by any of the following grounds:

(1) Willfully false information provided to the commission concerning a material issue in the case;

(2) Fraud perpetrated upon the commission by a witness, the respondent, or some person not the complainant;

(3) Material misrepresentations made by the respondent to the commission or complainant; or

(4) Gross and material error by the commission staff.

3.16(3) *Applications for reopening.*

a. Except where specifically otherwise provided, a complainant or respondent may apply for reopening of a previously closed proceeding.

b. The commission shall grant reopening upon good cause shown by the applicant.

c. An application for reopening under this subrule must be in writing alleging the grounds and must be filed within 30 days after the issuance of the decision or action to be reconsidered.

d. Written objections to a commission closure shall be liberally construed, where appropriate, as an application for reopening.

e. Unless the application for reopening is disposed of by summary denial, all parties shall be notified whenever an application for reopening is made. A copy of the request for reopening along with the grounds asserted in the request shall be provided to all respondents. The parties shall be afforded no less than 14 and no more than 30 days to submit their positions, in writing, on the motion for reopening.

The commission may summarily deny an application for reopening without seeking additional information and without following any of the procedures set forth in paragraph 3.16(3)*"e."* Summary denial is appropriate when the application for reopening either fails to assert any grounds for reopening or asserts grounds which are inadequate to justify reopening.

f. The commission, a commissioner, the executive director or designee may grant or deny the application for reopening. If the application for reopening is granted, the matter shall be referred back to the investigating staff. If no further investigation is required, the commission shall decide the matter on the accumulated record of the case. Each of the parties shall be informed of the action taken on the application to reopen, in writing, either by regular or certified mail.

g. When the commission denies an application for reopening of an administrative closure, the notice of the denial may be made by regular mail. The date of the denial is the date the denial decision is mailed. The date of mailing is presumed to be the date on the cover letter accompanying the denial unless this date is shown to be in error.

3.16(4) *No probable cause determination reopening.* In addition to the reopening provisions of subrule 3.16(3), within one year after issuance of a no probable cause, the commission may, in its discretion, reopen and reconsider that no probable cause order where either:

a. The commission finds that the no probable cause order was influenced in substantial part by any of the following:

(1) Fraud perpetrated upon the commission by some person who is not the complainant; or

(2) Material misrepresentations made by the respondent to the commission or complainant.

b. Less than 30 days have elapsed since the issuance of the no probable cause order and the commission determines, in its discretion, that the interests of justice require the matter to be reopened and reconsidered.

3.16(5) *Successful conciliation, mediation, satisfactorily adjusted and withdrawal reopening.*

a. Breach.

(1) Application. A party to a settlement agreement may, within 90 days of the date respondent's performance under the agreement was to be completed, apply for reopening of a case which has been closed as satisfactorily adjusted on the grounds that the other party has materially breached the agreement. The commission shall not consider such an application for reopening if the commission is a party to the agreement alleged to have been breached. Also, the commission shall not consider such an application for reopening unless, as a part thereof, the party seeking the reopening agrees in writing that if the reopening is granted the agreements allegedly breached shall be null and void, and that such party waives and releases any rights to seek specific performance or damages for the alleged breach in court. If the commission finds that the agreement has been materially breached and that the respondent did not negotiate the agreement in good faith, the case shall be reopened.

(2) Notification of parties. All parties shall be notified that an application for reopening has been made. A copy of the request for reopening along with the grounds asserted in the request for reopening shall be provided to all respondents. The parties shall be afforded no less than 14 and no more than 30 days to submit their position on the motion for reopening in writing.

(3) Court action upon breach. The right to seek reopening under the provisions of paragraph *"a"* shall not affect a party's right to proceed in district court on an action for breach of contract based on the settlement agreement. Upon confirmation that a party has filed such an action for breach of contract, however, the commission shall close the case as that party's remedy shall lie in the district court. If so ordered by the court in such an action, the commission shall reopen a matter that had been closed as a result of the satisfactory adjustment.

b. Coercion or duress.

(1) Application. A party to an agreement may within 90 days after the closure apply for reopening of a case which has been closed as conciliated, mediated or satisfactorily adjusted on the grounds that the agreement was not entered into voluntarily.

(2) Notice to parties. All parties shall be notified that an application for reopening has been made. A copy of the request for reopening along with the grounds asserted in the request for reopening shall be provided to all respondents. The parties shall be afforded no less than 14 and no more than 30 days to submit their position on the motion for reopening in writing.

(3) Standard. An application for reopening under this paragraph must be supported by affidavit. There is a presumption that a person signing a settlement agreement has done so voluntarily. If the commission finds that the agreement was not entered into voluntarily, then the case shall be reopened.

(4) Ratification. A party is barred from applying for reopening of a case on the ground that the agreement was involuntary, if the party has voluntarily accepted all benefits of an agreement.

c. Withdrawal.

(1) In general. A person whose case has been closed as "withdrawn" may within 90 days after the closure apply for reopening of that case.

(2) Standard. An application for reopening under this paragraph must be supported by affidavit. There is a presumption that a person filing a withdrawal has done so voluntarily and with the intent that the charge be withdrawn. If the commission finds that the request for withdrawal either was not filed voluntarily or was filed as a result of a mistake concerning the effect of the request for withdrawal, the case shall be reopened.

(3) Ratification. If the withdrawal is filed pursuant to a conciliation, mediation or other settlement agreement and the complainant has ratified that agreement, the complainant is barred from applying for reopening of the case on the ground that the agreement was not voluntary.

3.16(6) *Probable cause determination.* The provisions of subrule 3.16(3) notwithstanding, a respondent may not apply for reconsideration of a finding of probable cause.

3.16(7) *Decision to proceed to hearing.* The provisions of subrule 3.16(3) notwithstanding, a complainant may not apply for reopening of a case which has had a finding of probable cause but which is administratively closed because it is determined that the record does not justify proceeding to hearing.

3.16(8) *Request for right-to-sue reopening.* The commission may reopen any case which has been administratively closed whenever: a request for an administrative release is received, all the conditions for issuance of the administrative release are satisfied, and none of the exceptions set forth in subrule 3.10(4) apply. This type of reopening is made in order to effect the complainant's statutory right to receive an administrative release. A reopening under this subrule need not be separately made and issued, but instead is inherent in the issuance of the right to sue.

3.16(9) *Issuance of right to sue.*

a. The issuance of a right-to-sue letter may not be reconsidered and a case closed after such an issuance may not be reopened.

b. If the right-to-sue letter was issued to a complainant who had not requested it and the commission notifies the parties of this error within 90 days of the erroneous issuance, then the closure after the erroneous issuance of the right-to-sue letter will be deemed void and the case reopened.

3.16(10) *Notice of reopening.* Whenever the commission reopens or reconsiders a decision, case closure, or other action of the commission, the commission shall mail each of the parties notice of the reopening in writing sent by regular or certified mail to the last-known mailing address.

3.16(11) *Effect of reopening.* Whenever a case is reopened by the commission, whether upon application or otherwise, the previous closure of the case is made void. The previous closure of a reopened case has no effect whatsoever on the case after the reopening. A reopening constitutes a reversal of the prior determination to close the case.

[**ARC 8745B**, IAB 5/5/10, effective 6/9/10]

161—3.17(216) Arbitration. Rescinded IAB 5/5/10, effective 6/9/10.

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[1] The Administrative Rules Review Committee at its May 21, 1979, meeting delayed the effective date of 240—subrules 1.1(7) to 1.1(9), 1.3(1), 1.8(2) and rules 1.16 and 1.17 70 days.

[2] Effective date of 161—3.2(4), 3.2(5), 3.3(3), 3.4(216), 3.5(216), 3.7(3), 3.8(216), 3.10(216), 3.12(216), 3.13(8) to 3.13(10), 3.14(216) and 3.16(216) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 1993; delayed until adjournment of the 1994 Session of the General Assembly by this Committee May 11, 1993.

CHAPTER 4
CONTESTED CASES

[Prior to 1/13/88, see Civil Rights 240—1.5(2), 1.5(3), 1.8 to 1.15, 1.18]

161—4.1(17A) General provisions.

4.1(1) *Scope and applicability.* This chapter applies to contested case proceedings conducted by the Iowa civil rights commission.

4.1(2) *Prosecutory representative of commission.* The commission's case in support of the complaint shall be presented by the attorney or agent of the commission. An assistant attorney general may represent the Iowa civil rights commission at a contested case proceeding.

4.1(3) *Time.* Time shall be computed as provided in Iowa Code subsection 4.1(34).

4.1(4) *Modification of time limits.* For good cause shown, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

4.1(5) *Extension of time for service by mail.* Whenever a party has the right or is required by this chapter to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon that party and the notice or paper is served upon that party by mail, three days shall be added to the prescribed period. Such additional time shall not be applicable where the presiding officer has prescribed the method of service of notice and the number of days to be given. This rule has no effect on actions which must be taken within a prescribed period after the issuance of a proposed decision or final order.

161—4.2(17A) Notice of hearing and answer.

4.2(1) *Statement of charges.*

a. Where conciliation efforts fail and it is determined that the record justifies proceeding to hearing, the commission's attorney or the executive director shall prepare a written statement of charges in support of the complaint and forward it to the presiding officer together with a request for a hearing date.

b. The statement of charges shall contain:

(1) An allegation that the respondent is a proper respondent within the meaning of and subject to provisions of the Iowa civil rights Act.

(2) A factual allegation or allegations of an unfair or discriminatory practice or practices, substantially as uncovered in the investigation, stated in the complaint (including amendments thereto), stated in the order of probable cause, or stated in the investigative summary.

c. A statement of charges is sufficient if it:

(1) Names the respondents and complainants;

(2) States the section(s) of the statute alleged to be violated; and

(3) Incorporates by reference the complaint and any amendments to the complaint.

d. The statement of charges shall also specifically identify all allegations, if any, in the complaint, as amended, which:

(1) Have been closed by other than a probable cause finding, or

(2) The commission has elected not to prosecute despite a probable cause finding.

e. None of the allegations identified pursuant to paragraph 4.2(1)*"d"* shall be considered as a claim of discrimination in the contested case proceeding, but evidence on such allegations may be considered when relevant to other allegations of discrimination or as background evidence.

4.2(2) *Scheduling conference.*

a. The presiding officer may set the matter for a scheduling conference in order that the parties, including the commission, and the presiding officer may arrive at a mutually agreed date for the public hearing. If practicable, the scheduling conference should be set for no sooner than 7 and no later than 30 days after the presiding officer receives the statement of charges. The parties may be notified by regular

mail of the date of the scheduling conference. The scheduling conference may be conducted in whole or in part by telephone.

b. If no date can be agreed upon, the date of the public hearing may be set according to the presiding officer's discretion.

c. A public hearing should be scheduled for as early a date as practicable. In setting the date of hearing the availability of the presiding officer, the parties, the attorneys involved, likely witnesses, and any special circumstances shall be considered.

d. In setting the place of hearing, the location of the presiding officer, the parties, the attorneys involved, likely witnesses, and any special circumstances shall be considered.

4.2(3) *Notice of hearing.* Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery shall be executed by any of the following means: certified mail with return receipt requested, personal service as provided in the Iowa Rules of Civil Procedure, first-class mail, or publication as provided by the Iowa Rules of Civil Procedure to all interested parties or their attorneys at least 30 days before the date of the hearing. Certified mail return receipts, returns of service, or similar evidence of service shall be filed with the presiding officer. The notice shall include:

a. The time and place of hearing;

b. The nature of the hearing, the legal authority and jurisdiction under which the hearing is being held;

c. A short and plain statement of the matters asserted. This requirement may be satisfied by a statement of the issues as described by the statement of charges or an incorporation of the attached statement of charges;

d. The reference to the sections of the statute and rules involved;

e. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the commission and of parties' counsel where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Identification of the presiding officer, if known.

4.2(4) *Answer to notice of hearing.* The respondent is encouraged to file an answer to the allegations contained within the notice of hearing within 20 days of the service of the notice of hearing. Answers are encouraged as a means of sharpening the issues and preserving claimed error.

a. If an answer is filed, it should show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations contained within the notice of hearing. The answer should also state any facts alleged to show an affirmative defense and contain as many additional defenses as the respondent may claim.

b. An answer should state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf the answer is filed, and the attorney, if any, representing that person.

c. Failure to file an answer or failure to follow the guidelines of this rule does not by itself constitute a waiver of any argument nor an admission of any issue. The optional nature of the answer, however, does not affect the respondent's obligations to raise issues in a timely fashion, to reply to discovery, or to fulfill any other obligation which is imposed upon respondent by law.

4.2(5) *Presiding officer.*

a. The presiding officer assigned to render a proposed decision shall be an administrative law judge employed by the department of inspections and appeals.

b. As used in these rules the term "presiding officer" shall mean the administrative law judge employed by the department of inspections and appeals assigned to render a proposed decision in the contested case.

c. As used in rules 161—4.13(17A) and 161—4.14(17A) the term "presiding officer" shall include the commissioners of the Iowa civil rights commission as well as the administrative law judge assigned to render a proposed decision in the contested case.

161—4.3(17A) Amendment.

4.3(1) Any notice of hearing, petition, statement of charges, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive

pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance. Leave to amend, including leave to amend to conform to the proof, shall be freely given when justice so requires.

4.3(2) Amendment to conform to proof. When issues not raised by the notice of hearing or the answer are tried by express or implied consent of the parties, they shall be treated in all respects as if they had been raised in the pleadings. Such amendment of the pleadings as may be necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time, even after the final decision; but failure so to amend does not affect the result of the trial of these issues. If evidence is objected to at the hearing on the ground that it is not within the issues made by the pleadings, the presiding officer may allow the pleadings to be amended and shall do so freely when the presentation of the merits of the action will be served thereby and the objecting party fails to satisfy the presiding officer that the admission of such evidence would prejudice that party in maintaining the action or defense upon the merits. The presiding officer may grant a continuance to enable the objecting party to meet such evidence.

161—4.4(17A) Default.

4.4(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

4.4(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

4.4(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 161—4.23(17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

4.4(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

4.4(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

4.4(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 236.

4.4(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 161—4.25(17A).

4.4(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

4.4(9) A default decision may award any relief consistent with the notice of hearing and the commission's remedial authority under the Iowa civil rights Act.

4.4(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately.

161—4.5(17A) Consolidation and severance.

4.5(1) *Grounds for consolidation.* The presiding officer may, upon motion, consolidate any or all matters at issue in two or more contested case proceedings where:

a. The matters at issue involve common parties or common questions of fact or law;

b. Consolidation would expedite and simplify consideration of the issues involved; and

c. Consolidation would not adversely affect the rights of any of the parties to those proceedings.

4.5(2) *Effect of consolidation.* Where consolidated hearings are held, a single record of the proceedings may be made and the evidence introduced in one matter may be considered as introduced in the other, and a separate or joint decision shall be made at the discretion of the presiding officer.

4.5(3) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

161—4.6(17A) Filing and service of documents.

4.6(1) *When service required.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every other paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the commission, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

4.6(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivering, mailing, or transmitting by fax (facsimile) a copy to the attorney or to the party at the attorney's or party's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule or order.

4.6(3) *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers shall be filed with the presiding officer at the following address: Civil Rights Administrative Law Judge (or the name of the presiding officer), Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Except as provided by these rules, the Iowa Rules of Civil Procedure pertaining to discovery, or other law, all pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the presiding officer.

4.6(4) *Filing—how and when made.* In a contested case before the commission a document is filed by any of the methods described in 481—subrule 10.12(3). The date a document is deemed to be filed in a contested case before the commission is determined according to 481—subrule 10.12(3).

4.6(5) *Proof of mailing.*

a. In a contested case before the commission proof of mailing is made according to 481—subrule 10.12(4).

b. Conflict among proofs of mailing . The date of mailing is the date shown by the legible United States Postal Service postmark and, only in the absence of a legible postmark, the date of mailing is the date shown by the affidavit, certificate, or certification of mailing.

161—4.7(17A) Discovery.

4.7(1) *Civil procedure rules govern discovery.* Discovery procedures applicable in civil actions, as set forth in the Iowa Rules of Civil Procedure, are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

4.7(2) *Motions relating to discovery.* Any motion relating to discovery shall allege that the moving party has made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 4.7(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

4.7(3) *Use at hearing.* Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

4.7(4) *Sanctions available.* The Iowa Rules of Civil Procedure govern what sanctions may be imposed by the presiding officer for the failure to comply with a discovery order, the failure to respond to discovery, or failing to otherwise comply with the rules of discovery.

4.7(5) *Discovery on commission and complainant.* When discovery of information from the complainant is sought, discovery should be made upon the complainant with a copy thereof provided to the commission's representative. When discovery of information from the commission is sought, discovery should be made upon the commission with a copy thereof provided to the complainant or the complainant's representative. Discovery of the commission's investigative file may be made pursuant to Iowa Code section 17A.13(2).

4.7(6) *Discovery materials not filed.* Unless otherwise ordered by the presiding officer, no deposition, notice of deposition, interrogatory, request for production of documents, request for admission, or response, document or thing produced, or objection thereto shall be filed. Any motion attacking the sufficiency of a response to a discovery request must have a copy of the request and response attached or the motion may be denied. This rule does not apply to depositions to perpetuate testimony.

4.7(7) *Discovery conference.* A discovery conference may be ordered, requested, and held in the same manner and upon the same terms as are provided for in Iowa Rule of Civil Procedure 124.2.

4.7(8) *Duplication of civil procedure rules.* The duplication in these rules of provisions contained within the Iowa Rules of Civil Procedure relating to discovery does not imply that other portions of the civil procedure rules do not govern discovery in contested cases before the commission.

161—4.8(17A) Subpoenas.

4.8(1) *Issuance of subpoenas.*

a. A commission subpoena shall be issued to a party upon request. Such a request should be in writing, but oral requests may be honored by the presiding officer. The request shall include the name, address, and telephone number of the requesting party. The presiding officer may issue a subpoena, or a subpoena for the production of documentary evidence, signed but otherwise in blank to a party requesting it, who shall fill it in before service.

b. Parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

4.8(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

161—4.9(17A) Motions.

4.9(1) *Form.* No technical form for motions is required. However prehearing motions must be in writing, state the grounds for relief, and state the relief sought. Any motion for summary judgment shall comply with the Iowa Rules of Civil Procedure. Motions made during the hearing may be stated orally upon the record.

4.9(2) *Response.* Any party may file a written response to a motion within 14 days after the motion is served, unless the time period is extended or shortened by the rules of the commission or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

4.9(3) *Oral argument.*

a. The presiding officer may schedule oral argument on any motion.

b. Oral arguments on motions shall be held in Des Moines or by telephone conference call, unless the presiding officer orders otherwise.

c. A record of arguments will be made at the discretion of the presiding officer. A record may be made by tape recording or by certified shorthand reporter.

d. The expense of transcribing a record of the oral argument or any part thereof shall be charged to the requesting party.

4.9(4) *Motions regarding hearing.*

a. Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action

or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

b. Motions regarding sequestration of witnesses need not be made ten days prior to the hearing.

4.9(5) *Motions for summary judgment.* Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 237 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least 45 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to rule 4.30(17A) and appeal pursuant to rule 4.23(17A).

161—4.10(17A) Prehearing conferences.

4.10(1) Subject matter of conference. Upon the presiding officer's own motion or the motion of the parties, the presiding officer may direct the parties or their counsel to meet with the presiding officer for a conference to consider:

a. Simplification of the issues;

b. Necessity or desirability of amendments to pleadings for purposes of clarification, simplification, or limitation;

c. Stipulations, admissions of fact and of contents and authenticity of documents;

d. Limitation of number of witnesses;

e. Scheduling dates for the exchange of witness lists and proposed exhibits;

f. Identifying matters which the parties intend to request be officially noticed;

g. Such other matters, including discovery matters, as may tend to expedite the disposition of the proceedings.

4.10(2) Prehearing conferences shall be conducted by telephone unless otherwise ordered. A record of the conference will be kept unless otherwise ordered by the presiding officer. A record of the conference may be by tape recording or by certified shorthand reporter. A party may request a copy of the tape recording or transcript of the conference, if it was recorded; or a transcript of the conference, if it was reported, and the requesting party will bear the cost of the recording or transcription.

4.10(3) Effect of conference. The record shall show the matters disposed of by order and by agreement in such pretrial conferences. The subsequent course of the proceeding shall be controlled by such action.

161—4.11(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

4.11(1) Written or oral motions for continuance. A written motion for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

An oral motion for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making an oral motion for a continuance must confirm that request by written motion within five days after the oral request unless that requirement is waived by the presiding officer. No motion for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible.

4.11(2) Factors to consider. In determining whether to grant a continuance, the 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 requirement;
g. The existence of a conflict in the schedules of counsel, parties, and witnesses;
h. The timeliness of the request; and
i. Other relevant factors.

4.11(3) The presiding officer may require documentation of any grounds for continuance.

4.11(4) Failure of a party to timely obtain counsel, after clear and adequate notice of the right to be represented by an attorney, will not be considered grounds for a continuance in order to allow time to obtain counsel.

161—4.12(17A) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties or by order of the presiding officer. The presiding officer 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 location is chosen.

161—4.13(17A) Disqualification.

4.13(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

a. Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

4.13(2) 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 agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by 1998 Iowa Acts, chapter 1202, section 19(3), and subrules 4.13(3) and 4.14(8).

4.13(3) In a situation where a presiding officer or other person 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.

4.13(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 4.13(1), the party shall file a motion supported by an affidavit pursuant to 1998 Iowa Acts, chapter 1202, section 19(7). 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 the presiding officer determines that disqualification is appropriate, the presiding officer shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 161—4.25(17A).

4.13(5) Remittal of disqualification. A presiding officer disqualified by the terms of 4.13(1)*"e"* or *"f"* may, instead of withdrawing from the proceeding, disclose, either in writing or orally, on the record the basis of the disqualification. If, based on such disclosure, the parties and lawyers, independently of the administrative adjudicator's participation, all agree in writing that the adjudicator's relationship is immaterial or that the adjudicator's financial interest is insubstantial, the adjudicator is no longer disqualified, and may participate in the proceeding. The agreement, signed by all parties and lawyers, shall be incorporated in the record of the proceeding.

4.13(6) Partial disqualification of commission. The disqualification of one or more members of the commission who are considering adoption of a proposed decision of the presiding officer shall not prevent the remaining commissioners from considering the proposed decision.

161—4.14(17A) Ex parte communication.

4.14(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned to render a proposed or final decision or to make findings of fact or conclusions of law in the contested case from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 4.13(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

4.14(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

4.14(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

4.14(4) To avoid prohibited ex parte communications notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 161—4.6(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

4.14(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

4.14(6) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties

prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 161—4.11(17A).

4.14(7) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

4.14(8) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

4.14(9) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by agency personnel shall be reported to the executive director for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

161—4.15(17A) Powers of presiding officer. The presiding officer who presides at the hearing shall have all powers necessary to the conduct of a fair and impartial hearing including, but not limited to, the power to:

1. Conduct formal hearings in accordance with the provisions of this chapter;
2. Administer oaths and examine witnesses;
3. Compel the production of documents and appearance of witnesses in control of the parties;
4. Issue subpoenas;
5. Issue decisions and orders;
6. Rule on motions, and other procedural items or matters pending before the presiding officer;
7. Require the submission of briefs;
8. Issue such orders and rulings as will ensure the orderly conduct of the proceedings;
9. Receive, rule on, exclude or limit evidence and limit lines of questioning or testimony which are irrelevant, immaterial, or unduly repetitious;
10. Maintain the decorum of the hearing including the power to refuse to admit or to expel anyone whose conduct is disorderly;
11. Take any action authorized by these rules;
12. Impose appropriate sanctions against any party or person failing to obey an order under these rules which may include:

- Refusing to allow the disobedient party to support or oppose designated claims or defenses, or prohibiting the party from introducing designated matters in evidence;
- Excluding all testimony of an unresponsive or evasive witness, or determining that the answer of such witness, if given, would be unfavorable to the party, if any, having control over the witness; and
- Expelling any party or person from further participation in the hearing.

161—4.16(17A) Hearing procedures.

4.16(1) Objections. All objections shall be timely made and stated in the record. Any objection not duly made before the presiding officer shall be deemed waived.

4.16(2) Representation of parties. Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director or duly authorized agent. Any party may be represented by an attorney or another person authorized by law.

4.16(3) Rights of parties. 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.

4.16(4) Sequestration of witnesses. At the request of a party, a presiding officer may order witnesses sequestered so they cannot hear the testimony of other witnesses, and the judge may make the order sua sponte. This rule does not authorize sequestration of (a) a party who is a natural person, or (b) an officer or employee of a party which is not a natural person designated as its representative by its attorney, or (c) a person whose presence is shown by a party to be essential to the presentation of the cause.

4.16(5) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceeding;

b. The parties shall be given an opportunity to present an opening statement;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

4.16(6) Marking of exhibits. Exhibits entered into evidence which are offered by the commission or the complainant shall be numbered serially, i.e., 1, 2, 3, etc.; whereas those offered by the respondent shall be lettered serially, i.e., A, B, C, ...AA, BB, etc.; and those offered jointly shall be designated by "joint exhibit" and numbered serially.

4.16(7) Contents of record. The record in a contested case before the presiding officer shall include:

a. All pleadings, motions, and rulings;

b. All evidence received or considered and all other submissions;

c. A statement of matters officially noticed;

d. All questions and offers of proof, objections, and rulings thereon;

e. All proposed findings and exceptions;

f. Any decision, opinion or report by the officer presiding at the hearing.

The term "all other submissions" as used in this rule includes, but is not limited to, all written arguments filed with the presiding officer or the commission plus any attachments to such arguments.

Deliberations of the commission when deciding whether to adopt a proposed decision are not part of the record unless expressly made part of the record by order of the commission or the presiding officer.

4.16(8) Standards of conduct.

a. All persons appearing in proceedings before the presiding officer are expected to act with integrity, and in an ethical manner.

b. The presiding officer may exclude from proceedings parties, witnesses, and their representatives for refusal to comply with directions, continued use of dilatory tactics, refusal to adhere to reasonable standards of orderly and ethical conduct, failure to act in good faith, or violation of the prohibition against ex parte communications. The presiding officer shall state in the record the cause for barring an attorney or other individual from participation in a particular proceeding. The presiding officer may suspend the proceeding for a reasonable time for the purpose of enabling a party to obtain another attorney or representative. In accordance with Rule 1.2 of the Committee on Professional Ethics and Conduct of the Iowa State Bar Association, the presiding officer may also file a complaint with the committee if the judge believes that there has been a violation by an attorney of the Iowa Code of Professional Responsibility for Lawyers.

c. An order barring an individual from participation in a proceeding should be made only in exceptional circumstances.

161—4.17(17A) Evidence.

4.17(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

4.17(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts. Stipulated facts are binding on the presiding officer and the commission when it has not been proven that the stipulation was the result of fraud, wrongdoing, misrepresentation, or was not in accord with the intent of the parties.

4.17(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice by express or implied waiver, or the presiding officer determines that good cause justifies their expansion. If the presiding officer decides to admit evidence on issues outside the scope of notice over the objection of a party who did not have actual notice of those issues, that party, upon timely motion, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue. The scope of the issues at public hearing may include the facts as uncovered in the investigation and need not be limited to the allegations as stated in the original complaint.

4.17(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

4.17(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it 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 ruling until the written decision. Evidentiary objections, other than those based on relevancy, materiality, unduly repetitious evidence, privilege, discovery rules, or scope of examination, or any ground for which a ruling is compulsory as a matter of law, shall be simply noted in the record by the presiding officer.

4.17(6) Whenever evidence is ruled inadmissible, the party offering that exhibit 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 of exhibit, it shall be marked as part of an offer of proof and inserted in the record.

4.17(7) Although the rules of evidence do not apply in a contested case hearing, 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. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The commission shall give effect to the rules of privilege recognized by law.

4.17(8) The authenticity of all documents submitted as proposed exhibits at the prehearing conference shall be deemed admitted unless objection is made at the prehearing conference or a written objection to authenticity of a document is filed at least ten days prior to the hearing. A party will be permitted to challenge authenticity at a later time upon a clear showing of good cause for failure to have made the objection earlier. A party's objection to authenticity is that party's refusal to admit the fact of authenticity and need not be ruled upon to be effective. If authenticity is not admitted under this rule it may be proved at hearing by any means permitted by law.

4.17(9) No evidence shall be received at any hearing concerning offers or counter-offers of adjustment during efforts to conciliate or settle an alleged unfair or discriminatory practice.

161—4.18(17A) Evidence of past sexual practices.

4.18(1) Discovery regarding past sexual practices. In a contested case alleging conduct which constitutes sexual harassment, a party seeking discovery of information concerning the complainant's sexual conduct with persons other than the person who committed the alleged act of sexual harassment, must establish specific facts showing good cause for that discovery, and that the information sought is relevant to the subject matter of the action, and reasonably calculated to lead to the discovery of admissible evidence.

4.18(2) Evidence of past sexual practices inadmissible. In a contested case against a respondent who is accused of sexual harassment, or whose agent or employee is accused of sexual harassment, evidence concerning the past sexual behavior of the alleged victim is not admissible.

161—4.19(17A) Cost of copies of record. Upon request the commission shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record shall be paid by the requesting party.

161—4.20(17A) Posthearing briefs.

4.20(1) In general. The presiding officer may fix times for submission of posthearing briefs. Unless otherwise ordered by the presiding officer, such briefs shall be filed simultaneously by all parties and there shall be no page limit nor any other formal requirements.

4.20(2) Reply briefs. If simultaneous briefs are filed then any party may file a reply brief within 10 days after service of the brief to which the reply is made.

4.20(3) Supplemental briefs. Posthearing briefs in addition to those ordered by the presiding officer under subrule 4.20(1) or those allowed by subrule 4.20(2) may be filed only upon application to the presiding officer.

4.20(4) Extensions. A motion for an extension of the time to file a brief shall be made no later than the day before the brief is due. A motion for an extension to file a brief may be oral and may be granted ex parte where the movant represents either (*a*) that the other parties who are filing briefs have been notified and that the motion is unopposed or (*b*) that there is an emergency which justifies such a request. An order granting an extension shall be in writing.

4.20(5) Late filing. Upon motion and within the discretion of the presiding officer a brief which is filed late may be struck.

4.20(6) Failure in a party's briefs to state, to argue, or to cite authority in support of an issue may be deemed waiver of that issue by that party before the presiding officer.

161—4.21(17A) Requests to present additional evidence.

4.21(1) *In general.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence.

4.21(2) *After proposed decision issued.* If a request to present additional evidence is made after the issuance of the proposed decision by the presiding officer then the request must be filed with the appeal or, by a nonappealing party, within 14 days after the service of the appeal. If the commission grants the motion to present additional evidence, the commission shall remand the case to the presiding officer for the taking of the additional evidence and any appropriate modification of the proposed order.

161—4.22(17A) Proposed decision.

4.22(1) *Written decision.* After a review of the transcript, the evidence, and the briefs, the presiding officer shall set forth, in writing, findings of fact, conclusions of law, and a proposed decision and order. The proposed decision becomes the final decision of the commission without further proceedings unless there is an appeal to, or review on motion of, the Iowa civil rights commission within the time provided in rule 161—4.23(17A).

4.22(2) *Notification.* Upon receipt of the presiding officer's proposed decision, the commission shall forward a copy of the proposed decision to each of the parties by certified mail. A copy shall also be sent to counsel and to each commissioner.

161—4.23(17A) Review of proposed decision on appeal to the commission.

4.23(1) Appeal by party. Any adversely affected party may appeal a proposed decision to the commission within 30 days after issuance of the proposed decision.

4.23(2) Review. The commission may initiate review of a proposed decision on its own motion at any time within 60 days following the issuance of such a decision.

4.23(3) Notice of appeal. An appeal of a proposed decision is initiated by filing a timely notice of appeal with the Iowa civil rights commission. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

4.23(4) If an appeal or motion for review is filed, the executive director shall set a review date. The parties shall be notified of this date by certified mail. Copies of this notification shall also be sent to counsel and the commissioners.

4.23(5) An appeal is filed with the commission by delivering the notice of appeal to the commission at its offices in Des Moines. All appeals and briefs shall be sent to the executive director of the Iowa civil rights commission in care of the commission at its Des Moines address. An appeal may be filed by any of the methods described in 161—subrules 3.5(1) to 3.5(4). Regardless of the method used to file an appeal, the date an appeal is filed is the date it is actually received by the commission in Des Moines.

4.23(6) Oral argument. All parties or their attorneys shall be allowed ten minutes to present oral argument to the commission whenever the commission reviews a proposed decision pursuant to this rule. The commission may, in its discretion, allow oral argument to continue longer.

4.23(7) Briefs and arguments. Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. The commission may shorten or extend the briefing period as appropriate. When filing a brief the party shall file an original and nine copies.

161—4.24(17A) Scope of review by commission.

4.24(1) *In general.* Whenever the commission reviews a proposed decision, it has all the power it would have in initially making the final decision. The commission may adopt, modify or reject the presiding officer's proposed decision or it may remand the case to the presiding officer for the taking of additional evidence and the making of any further proposed findings of fact, conclusions of law, or decision and order the commission deems necessary.

4.24(2) *Limitation of issues.* Whenever the commission reviews a proposed decision it shall consider only those issues actually presented to the presiding officer unless the issue was one which either:

a. Was raised prior to the proposed decision by a party, but not ruled upon, or

b. Was discussed in the proposed decision, but not argued on brief by the parties.

This rule does not affect a party's right to seek disqualification of a commissioner under rule 161—4.13(17A) or 161—4.14(17A).

161—4.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the commission may review an interlocutory order of the presiding officer. In determining whether to do so, the commission shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the agency at the

time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request or motion for interlocutory review must be filed within seven days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

161—4.26(17A) Intervention.

4.26(1) *Motion.* A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

4.26(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

4.26(3) *Grounds for intervention.* The movant shall demonstrate that: (*a*) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (*b*) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (*c*) the interests of the movant are not adequately represented by existing parties.

4.26(4) *Effect of intervention.* If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

161—4.27(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

161—4.28(17A) Awards of attorney's fees.

4.28(1) *Retention of jurisdiction.* In any final decision in which it is determined that the complainant is entitled to an award of attorney's fees, but the actual amount has not yet been determined, there is, by operation of this rule, an express retention of jurisdiction of the case by the commission in order to determine the actual amount of attorney's fees to which the party is entitled and to enter a subsequent order awarding those fees. The commission shall take this action regardless of whether or not such retention of jurisdiction is expressed in the final decision. In such case, the decision is final in all other respects except the determination of the amount of the attorney's fees.

4.28(2) *Stipulation.* A final decision, in which it is determined that the complainant is entitled to an award of attorney's fees, may provide for an opportunity for the parties to file a written stipulation concerning the amount of the fees to be awarded. Any such stipulation entered into by the complainant(s) and respondent(s) is binding on the commission in the absence of evidence of fraud, wrongdoing, misrepresentation, or evidence that the stipulation is not in accord with the intent of the parties.

4.28(3) *Hearing.* If the amount of attorney's fees is not stipulated to by the parties, the presiding officer shall schedule a hearing on the issue of the amount of the attorney's fees. The hearing shall

be governed by the same procedures as a hearing on the merits of a complaint except where otherwise ordered by the presiding officer. The parties may elect, by written stipulation, to utilize some method, such as stipulation of facts or submission of a documentary record, other than or complementary to a hearing, in order to make a record on attorney's fees which may then be reviewed by the presiding officer. By operation of this rule, the commission expresses its consent to such stipulations if agreed to by the parties seeking and contesting attorney's fees. The record of the original hearing is part of the record on the attorney's fee issue. Regardless of the method by which the record is made, the complainant has the burden of persuasion in proving attorney's fees.
[**ARC 8737B**, IAB 5/5/10, effective 6/9/10]

161—4.29(17A) Waiver, modification of rules.

4.29(1) *By presiding officer.* Upon notice to all parties, the presiding officer may, with respect to matters pending before the presiding officer, modify or waive any rule herein upon a determination that no party will be prejudiced and that the ends of justice will be served.

4.29(2) *By parties.* Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the presiding officer, in the discretion of the presiding officer, may refuse to give effect to such a waiver when the presiding officer deems the waiver to be inconsistent with the public interest.

161—4.30(17A) Application for rehearing.

4.30(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

4.30(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the agency decision on the existing record and whether, on the basis of the grounds enumerated in rule 161—4.21(17A), the applicant requests an opportunity to submit additional evidence.

4.30(3) *Time of filing.* The application shall be filed with the commission at its offices in Des Moines within 20 days after the issuance of the final decision.

4.30(4) *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 commission shall serve copies on all parties.

4.30(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the agency grants the application within 20 days after its filing.

161—4.31(17A) Hearing—other reasons. At any other time, the commission, executive director, or designee may, at its discretion, convene a hearing: whenever a problem of discrimination arises; in order to expedite the disposition of preliminary matters in any action before it; or when in the judgment of the commission, executive director, or designee, the circumstances warrant.
[**ARC 8737B**, IAB 5/5/10, effective 6/9/10]

161—4.32(216) Assessment of costs of hearing.

4.32(1) *General rule.* If the complainant or the commission prevails in the hearing, the respondent shall pay the "contested case costs" incurred by the commission. If the respondent prevails in the hearing, the commission shall itself bear the "contested case costs" incurred by the commission.

4.32(2) *Mixed results.* Where the complainant or commission is successful as to part of the remedies sought at the hearing and unsuccessful as to part of the remedies, the administrative law judge may recommend an equitable apportionment of "contested case costs" between the commission and the respondent.

4.32(3) *Costs allowable.* The following "contested case costs" and no others will be assessed or apportioned as provided in subrule 4.32(1) or 4.32(2):

a. The daily charge of the court reporter for attending and transcribing the hearing.

b. All mileage charges of the court reporter for traveling to and from the hearing.

c. All travel time charges of the court reporter for traveling to and from the hearing.

d. The cost of the original of the transcripts of the hearing.

e. Postage incurred by the administrative law judge in sending by mail (regular or certified) any papers which are made part of the record.

4.32(4) *Remedial orders.* This rule does not affect those costs which may be recoverable under Iowa Code section 216.15(8)*"a"*(8).

161—4.33(216) Appeals to the district court. Appeals to the district courts from the decision of the commission shall be perfected pursuant to the provisions of Iowa Code section 216.17 and Iowa Code chapter 17A.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code chapter 216.

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[1] The Administrative Rules Review Committee at its May 21, 1979, meeting delayed the effective date of 240—subrules 1.1(7) to 1.1(9), 1.3(1), 1.8(2) and rules 1.16 and 1.17 70 days.

CHAPTER 6
DISCRIMINATION IN CREDIT

[Prior to 1/13/88, see Civil Rights 240—Ch 4]

161—6.1(216) Definitions.

"Credit" means an amount or limit to the extent a person may receive goods, services or money for payment in the future, and includes but is not limited to, loans for any purpose and in any amount, checking accounts, charge accounts, mortgages and other home financing, credit cards and credit ratings.

"Credit card" means a small card (as one issued by hotels, restaurants, stores, petroleum companies or banks) authorizing the person or company named or its agent to charge goods or services or borrow money.

"Credit institution" means banks, savings and loan associations, finance companies, credit departments of all retail businesses, credit rating services, credit card issuers, credit bureaus, credit unions and all other loan, credit, financing and mortgaging institutions.

161—6.2(216) Practices prohibited.

6.2(1) The criteria used to evaluate applicants for credit and the standards necessary to be met by the successful applicants shall be the same regardless of the age, color, creed, national origin, race, religion, marital status, sexual orientation, gender identity, sex or physical disability of the applicant.

6.2(2) No credit institution shall require any information, reference or countersignature of any applicant for credit which would not be required of all applicants, regardless of their age, color, creed, national origin, race, religion, marital status, sex or physical disability.

6.2(3) It shall be an unlawful practice for any credit institution to discount or disregard the earnings or income of a spouse in computing family income.

6.2(4) It shall be an unlawful practice for any credit institution to refuse to loan money or extend credit to a woman solely because she is in the childbearing years or solely because she is divorced, or solely because she is unmarried.

6.2(5) It shall be an unlawful practice for any credit institution to extinguish the established credit of any woman upon her marriage or to require that a new account be opened in the husband's name.

6.2(6) It shall be an unlawful practice for any credit institution to refuse to retain any records of credit transactions in the name of a married woman when she so requests in writing.

[**ARC 8744B**, IAB 5/5/10, effective 6/9/10]

161—6.3(216) Credit inquiries.

6.3(1) A credit application or credit interviewer may inquire as to age, disability, sex or marital status provided the inquiry is made in good faith for a nondiscriminatory purpose. Any inquiry which expresses directly or indirectly any limitation, specification, or discrimination as to age, disability, sex or marital status shall be unlawful.

6.3(2) The information required to be given by the applicant for credit should be limited to what is necessary for determining the applicant's financial conditions and prospects for repayment regardless of the applicant's age, color, creed, national origin, race, religion, marital status, sex or physical disability. The consent of a spouse shall not be required where the applicant is otherwise eligible for credit.

161—6.4(216) Exceptions.

6.4(1) Cosignatures may be required of a married couple intending to establish a joint account with the company or business issuing the credit card.

6.4(2) The exception for cosignatures is limited, and the issuer should presume the applicant is seeking a credit card in the applicant's own name regardless of the marital status of the applicant.

6.4(3) These rules shall not prohibit any party to a credit transaction from considering the application to the particular case of Iowa law on dower, title, descent, and distribution, or from taking constructive action thereon.

These rules are intended to implement Iowa Code chapter 216.

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CHAPTER 8
DISCRIMINATION IN EMPLOYMENT

PREAMBLE

GENERAL PRINCIPLES

References to "employer" and "employers" in these rules state principles that are applicable not only to employers but also to labor organizations and to employment agencies insofar as their action or inaction may adversely affect employment opportunities as defined in the Act (Iowa Code section 216.6).
[**ARC 8735B**, IAB 5/5/10, effective 6/9/10]

EMPLOYMENT SELECTION PROCEDURE

[Prior to 1/13/88, see Civil Rights 240—Chs 2, 3, 5, 6]

161—8.1(216) General provisions—employee selection procedures. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.2(216) Employment agencies and employment services. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.3(216) Disparate treatment. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.4(216) Retesting. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.5(216) Other selection techniques. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.6(216) Affirmative action. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.7(216) Remedial and affirmative action. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.8 to **8.14** Reserved.

AGE DISCRIMINATION IN EMPLOYMENT

161—8.15(216) Age discrimination in employment.

8.15(1) Any person who has reached 18 years of age may not be excluded from an employment right because of an arbitrary age limitation and shall be an aggrieved party for the purposes of Iowa Code section 216.15, regardless of whether the person is excluded by reason of excessive age or insufficient age, and shall possess all the rights and remedies for discrimination provided in section 216.15.

8.15(2) No employer, employment agency, or labor organization shall set an arbitrary age limitation in relation to employment or membership except as otherwise provided by commission rules or by the Iowa Code.

8.15(3) Help wanted notices. No newspaper or other publication published within the state of Iowa shall accept, publish, print or otherwise cause to be advertised any notice of an employment opportunity from an employer, employment agency, or labor organization containing any indication of a preference, limitation, or specification based upon age, except as provided in commission rules, unless the newspaper or publication has first obtained from the employer, employment agency, or labor organization an affidavit indicating that the age requirement for an applicant is a bona fide occupational qualification.

8.15(4) Help wanted notices of advertisements shall not contain terms and phrases such as "young," "boy," "girl," "college student," "recent college graduate," "retired person," or others of a similar nature unless there is a bona fide occupational requirement for the position.

8.15(5) Job applications for and other preemployment inquiries. An employer, employment agency or labor organization may make preemployment inquiry regarding the age of an applicant, provided that the inquiry is made in good faith for a nondiscriminatory purpose. Any preemployment inquiry

in connection with prospective employment which expresses directly or indirectly any limitation, specification, or discrimination as to age shall be unlawful unless based upon a bona fide occupational qualification. The burden shall be on the employer, employment agency or labor organization to demonstrate that the direct or indirect preemployment inquiry is based upon a bona fide occupational qualification.

8.15(6) Nothing in the above shall be construed to prohibit any inquiry as to whether an applicant is over 18 years of age.

8.15(7) Nothing in the above shall be construed to prohibit postemployment inquiries as to age where the inquiries serve legitimate record-keeping purposes.

8.15(8) Bona fide occupational qualifications.

a. An employer, employment agency, or labor organization may take any action otherwise prohibited under commission rules where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business.

b. The concept of the bona fide occupational qualification is narrow in scope and will not be applied to include the mere preference or convenience of the employer.

c. Age requirements set by federal or state statute or regulatory agency shall be considered to be bona fide occupational qualifications where requirements are necessarily related to the work which the employee must perform.

d. A bona fide occupational qualification will also be recognized where there exist special, individual occupational circumstances such as where actors are required for characterizations of individuals of a specified age, or where persons are used to advertise or promote the sale of products designed for, and directed to, certain age groups.

161—8.16(216) Bona fide apprenticeship programs. Where an age limit is placed upon entrance into an apprenticeship program, the limitation shall not be a violation of Iowa Code chapter 216 where the employer can demonstrate a legitimate economic interest in the limitation in terms of the length of the training period and the costs involved in providing the training. The age limit shall not be set any lower than reasonably necessary to enable the employer to recover the costs of training the employee and a reasonable profit.

161—8.17(216) Employment benefits.

8.17(1) An employer is not required to provide the same pension, retirement, or insurance benefits to all employees where the cost varies with the age of the individual employee. Business necessity or bona fide underwriting criteria shall be the only basis used by employers for providing different benefits to employees of different ages unless the benefits are provided under a retirement plan or benefit system not adopted as a mere subterfuge to evade the purposes of the Act.

8.17(2) The existence of a provision in a retirement plan stating a maximum eligibility age for entrance into a retirement plan shall not authorize rejecting from employment an applicant who is over the maximum eligibility age for the retirement plan.

161—8.18(216) Retirement plans and benefit systems.

8.18(1) Commission rules shall not be construed so as to prohibit an employer from retiring an employee, or to require an employer to hire back an employee following retirement, or to hire an applicant for employment whose age is the retirement age under the employer's retirement plan or benefit system, provided that the plan or system is not a mere subterfuge for the purpose of evading the provisions of the Act.

8.18(2) However, a retirement plan or benefit system shall not require the involuntary retirement of a person under the age of 70 because of that person's age, with the following exceptions:

a. Peace officers, in the divisions of highway safety and uniformed force, criminal investigation and bureau of identification, drug law enforcement, beer and liquor law enforcement, police officers, firefighters, and conservation officers, so long as their maximum age by statute is 65 years;

b. Bona fide executives and high policymaking employees who have served in that capacity for the two prior years who are entitled to an immediate, nonforfeitable annual retirement benefit from a pension, profit-sharing, savings or deferred compensation plan of the employer which equals $27,000; and

c. The involuntary retirement of a person covered by collective bargaining agreement which was entered into by a labor organization and was in effect on September 1, 1977. This exemption does not apply after termination of that agreement or January 1, 1980, whichever first occurs.

8.18(3) State employees who are members of the Iowa public employee's retirement system are not subject to mandatory retirement based on age.

161—8.19 to **8.25** Reserved.

DISABILITY DISCRIMINATION IN EMPLOYMENT

161—8.26(216) Disability discrimination in employment.

8.26(1) The term "substantially handicapped person" shall mean any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

8.26(2) The term "physical or mental impairment" means:

a. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or

b. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

8.26(3) The term "major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

8.26(4) The term "has a record of such an impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

8.26(5) The term "is regarded as having an impairment" means:

a. Has a physical or mental impairment that does not substantially limit major life activities but that is perceived as constituting such a limitation;

b. Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

c. Has none of the impairments defined to be "physical or mental impairments," but is perceived as having such an impairment.

8.26(6) The term "employer" shall include any employer, as defined in Iowa Code section 216.2(5), and labor organization, or employment agency insofar as their action or inaction may adversely affect employment opportunities.

161—8.27(216) Assessment and placement.

8.27(1) If examinations or other assessments are required, they should be directed toward determining whether an applicant for a job:

a. Has the physical and mental ability to perform the duties of the position. An individual applicant would have to identify the position for which the applicant has applied.

b. Is physically and mentally qualified to do the work without adverse consequences such as creating a danger to life or health of coemployees.

c. Is professionally competent or has the necessary skills or ability to become professionally competent to perform the duties and responsibilities which are required by the job.

8.27(2) Examinations or other assessments should consider the degree to which the person has compensated for the person's limitations and the rehabilitation service that person has received.

8.27(3) Physical standards for employment should be fair, reasonable, and adapted to the actual requirements of the employment. They shall be based on complete factual information concerning working conditions, hazards, and essential physical requirements of each job. Physical standards will not be used to arbitrarily eliminate the disabled person from consideration.

8.27(4) Where preemployment tests are used, the opportunity will be provided applicants with disabilities to demonstrate pertinent knowledge, skills and abilities by testing methods adapted to their special circumstances.

8.27(5) Probationary trial periods in employment for entry-level positions which meet the criteria of business necessity may be instituted by the employer to prevent arbitrary elimination of the disabled.

8.27(6) Reasonable accommodation. An employer shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the employer can demonstrate that the accommodation would impose an undue hardship on the operation of its program.

a. Reasonable accommodation may include:

(1) Making facilities used by employees readily accessible to and usable by handicapped persons, and

[1](2) Job restructuring, part-time or modified work schedules, acquisition or modification of equipment or devices, the provision of readers or interpreters, and other similar actions.

[1]*b.* In determining pursuant to the first paragraph of this subrule whether an accommodation would impose an undue hardship on the operation of an employer's program, factors to be considered include:

(1) The overall size of the employer's program with respect to number of employees, number and type of facilities, and size of budget;

(2) The type of the employer's operation, including the composition and structure of the employer's workforce; and

(3) The nature and cost of the accommodation needed.

c. An employer may not deny any employment opportunity to a qualified handicapped employee or applicant if the basis for the denial is the need to make reasonable accommodation to the physical or mental limitations of the employee or applicant.

8.27(7) Occupational training and retraining programs, including but not limited to guidance programs, apprentice training programs, on-the-job training programs and executive training programs, shall not be conducted in a manner to discriminate against persons with physical or mental disabilities.

[1] Objection to 8.27(6)*"a"*(2) and 8.27(6)*"b"* [prior to 1/13/88 numbered as 6.2(6)*"a"*(2) and 6.2(6)*"b,"* respectively,] reimposed 4/20/88, republished 5/4/88; see full text of objection at end of chapter.

161—8.28(216) Disabilities arising during employment. When an individual becomes disabled, from whatever cause, during a term of employment, the employer shall make every reasonable effort to continue the individual in the same position or to retain and reassign the employee and to assist that individual's rehabilitation. No terms in this rule shall be construed to mean that the employer must erect a training and skills center.

161—8.29(216) Wages and benefits.

8.29(1) While employers may reengineer the conditions of work for the disabled person, the salary paid to the person shall be no lower than the lowest listed on the applicable wage grade schedule.

8.29(2) The wage schedule must be unrelated to the existence of physical or mental disabilities.

8.29(3) It shall be an unfair employment practice for an employer to discriminate between persons who are disabled and those who are not, with regard to fringe benefits, unless there are bona fide underwriting criteria.

8.29(4) A condition of disability shall not constitute a bona fide underwriting criteria in and of itself.

161—8.30(216) Job policies.

8.30(1) Written personnel policies relating to this subject area must expressly indicate that there shall be no discrimination against employees on account of disability.

8.30(2) If the employer deals with a bargaining representative for the employees and there is a written agreement on conditions of employment, it shall not be inconsistent with these guidelines.

161—8.31(216) Recruitment and advertisement.

8.31(1) It shall be an unfair employment practice for any employer to print or circulate or cause to be printed or circulated any statement, advertisement, or publication or to use any form of application preemployment inquiry regarding mental or physical disability for prospective employment which is not a bona fide occupational qualification for employment and which directly or indirectly expresses any negative limitations, specifications, or discrimination as to persons with physical or mental disabilities. The burden shall be on the employer to demonstrate that the statement, advertisement, publication or inquiry is based upon a bona fide occupational qualification. This is subject, however, to the provisions of Iowa Code section 216.6(1)*"c."*

8.31(2) It shall be an unfair employment practice to ask any question on the employment application form regarding a physical or mental disability unless the question is based upon a bona fide occupational qualification. The burden will be on the employer to demonstrate that the question is based upon a bona fide occupational qualification.

8.31(3) An employment interviewer may inquire as to a physical or mental disability provided the inquiry is made in good faith for a nondiscriminatory purpose.

161—8.32(216) Bona fide occupational qualifications.

8.32(1) It shall be lawful for an employer, employment agency, or labor organization to take any action otherwise prohibited under these rules where mental or physical ability is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business.

8.32(2) The concept of the bona fide occupational qualification is narrow in scope and will not be applied to include the mere preference or convenience of the employer.

8.32(3) Physical or mental disability requirements set by federal or state statute or regulatory agency shall be considered to be bona fide occupational qualifications where the requirements are necessarily related to the work which the employee must perform.

161—8.33 to **8.45** Reserved.

SEX DISCRIMINATION IN EMPLOYMENT

161—8.46(216) General principles. Rescinded IAB 5/5/10, effective 6/9/10.

161—8.47(216) Sex as a bona fide occupational qualification. The bona fide occupational qualification exception as to sex is strictly and narrowly construed. Labels—"men's jobs" and "women's jobs"—tend to unnecessarily deny employment opportunities to one sex or the other.

8.47(1) The following situations do not warrant a bona fide occupational qualification exception:

a. The refusal to hire an individual because of gender, based on assumptions of the comparative employment characteristics of that gender in general;

b. The refusal to hire an individual based on stereotypical characterizations of the sexes, for example, that men are less capable of assembling intricate equipment or that women are less capable of aggressive sales work. The principle of nondiscrimination requires that individuals be considered on the basis of individual capacities and not on the basis of any characteristics generally attributed to the group;

c. The refusal to hire an individual because of the preferences of coworkers, the employer, clients or customers, except as covered specifically in 8.47(2).

8.47(2) Where it is necessary for the purpose of authenticity or genuineness, sex is a bona fide occupational qualification, e.g., an actor or actress.

[**ARC 8736B**, IAB 5/5/10, effective 6/9/10]

161—8.48(216) Recruitment and advertising.

8.48(1) Employers engaged in recruiting activity must recruit employees of both sexes for all jobs unless sex is a bona fide occupational qualification.

8.48(2) Advertisement in newspapers and other media for employment must not express a sex preference unless sex is a bona fide occupational qualification. The placement of an advertisement in columns headed "male" or "female" will be considered an expression of a preference, limitation, specification or discrimination based on sex.

161—8.49(216) Employment agencies.

8.49(1) Iowa Code sections 216.6(1)*"a"* and *"c"* specifically state that it shall be unlawful for an employment agency to discriminate against any individual because of sex. Private employment agencies which deal exclusively with one sex are engaged in an unlawful employment practice, except to the extent that agencies limit their services to furnishing employees for particular jobs for which sex is a bona fide occupational qualification.

8.49(2) An employment agency that receives a job order containing an unlawful sex specification will share responsibility with the employer placing the job order if the agency fills the order knowing that the sex specification is not based upon a bona fide occupational qualification. However, an employment agency is not in violation of the law, regardless of the determination as to the employer, if the agency does not have reason to believe that the employer's claim of bona fide occupational qualification is without substance and the agency makes and maintains a written record available to the commission of each job order. The record shall include the name of the employer, the description of the job and the basis for the employer's claim of bona fide occupational qualification.

8.49(3) It is the responsibility of employment agencies to keep informed of opinions and decisions of the commission on sex discrimination.

161—8.50(216) Preemployment inquiries as to sex. A preemployment inquiry may ask "male . . ., female . . .,"; or "Mr., Mrs., Miss" provided that the inquiry is made in good faith for a nondiscriminatory purpose. Any preemployment inquiry which expresses directly or indirectly a limitation, specification, or discrimination as to sex shall be unlawful unless based upon a bona fide occupational qualification.

161—8.51(216) Job policies and practices.

8.51(1) Written personnel policies relating to this subject area must expressly indicate that there shall be no discrimination against employees on account of sex. If the employer deals with a bargaining representative for the employer's employees and there is a written agreement on conditions of employment, the agreement shall not be inconsistent with these guidelines.

8.51(2) Employees of both sexes shall have an equal opportunity to any available job that the employee is qualified to perform, unless sex is a bona fide occupational qualification.

8.51(3) No employer shall make any distinction based upon sex in employment opportunities, wages, hours, or other conditions of employment. In the area of employer contributions for insurance, pensions, welfare programs and other similar "fringe benefits" the employer will not violate these guidelines if the employer's contributions are the same for both sexes or if the resulting benefits are equal.

8.51(4) Any distinction between married and unmarried persons of one sex that is not made between married and unmarried persons of the opposite sex will be considered to be a distinction made on the basis of sex. Similarly, an employer must not deny employment to women with young children unless it has the same exclusionary policies for men; nor terminate an employee of one sex in a particular job classification upon reaching a certain age unless the same rule is applicable to members of the opposite sex.

8.51(5) The employer's policies and practices must ensure appropriate physical facilities to both sexes. The employer may not refuse to hire either sex, or deny either sex a particular job because there are no restroom or associated facilities, unless the employer is able to show that the construction of the facilities would be unreasonable for such reasons as excessive expense or lack of space.

8.51(6) An employer must not deny a female employee the right to any job that she is qualified to perform. For example, an employer's rules cannot bar a woman from a job that would require more than a certain number of hours or from working at jobs that require lifting or carrying more than designated weights.

161—8.52(216) Separate lines of progression and seniority systems.

8.52(1) It is an unlawful employment practice to classify a job as "male" or "female" or to maintain separate lines of progression or separate seniority lists based on sex where this would adversely affect any employee unless sex is a bona fide occupational qualification for that job. Accordingly, employment practices are unlawful which arbitrarily classify jobs so that:

a. A female is prohibited from applying for a job labeled "male," or for a job in a "male" line of progression, and vice versa;

b. A male scheduled for layoff is prohibited from displacing a less senior female on a "female" seniority list; and vice versa.

8.52(2) A seniority system or line of progression which distinguishes between "light" and "heavy" jobs constitutes an unlawful employment practice if it operates as a disguised form of classification by sex, or creates unreasonable obstacles to the advancement by members of either sex into jobs which members of that sex would reasonably be expected to perform.

161—8.53(216) Discriminatory wages.

8.53(1) The employer's wage schedules must not be related to or based on the sex of the employees.

8.53(2) The employer may not discriminatorily restrict one sex to certain job classifications. The employer must take steps to make jobs available to all qualified employees in all classifications without regard to sex.

161—8.54(216) Terms and conditions of employment.

8.54(1) It shall be an unlawful employment practice for an employer to discriminate between either sex with regard to terms and conditions of employment.

8.54(2) Difference in benefits on a sexual basis.

a. Where an employer conditions benefits available to employees and their spouses and families on whether the employee is the "head of the household" or "principal wage earner" in the family unit, the benefits tend to be available only to male employees and their families. Due to the fact that these conditions discriminatorily affect the rights of women employees, and that "head of household" or "principal wage earner" status bears no relationship to job performance, benefits which are so conditioned will be found to be a prima facie violation of the prohibition against sex discrimination contained in the Act.

b. It shall be an unlawful employment practice for an employer to make available benefits for the wives and families of male employees where the same benefits are not made available for the husbands and families of female employees; or to make available benefits for the wives of male employees which are not made available for female employees; or to make available benefits to the husbands of female employees which are not made available for male employees.

c. It shall not be a defense to a charge of sex discrimination in benefits under Iowa Code chapter 216 that the cost of benefits is greater with respect to one sex than the other.

8.54(3) A health insurance program provided in whole or in part by an employer shall include coverage for pregnancy-related conditions; the plan may exclude coverage of abortion, except where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion.

161—8.55(216) Employment policies relating to pregnancy and childbirth.

8.55(1) A written or unwritten employment policy or practice which excludes from employment applicants or employees because of pregnancy is a prima facie violation of Iowa Code chapter 216, and may be justified only upon showing of business necessity.

8.55(2) Disabilities caused or contributed to by pregnancy, miscarriage, childbirth, and recovery therefrom are, for all job-related purposes, temporary disabilities and should be treated as such under any health or temporary disability insurance or sick leave plan available in connection with employment. Written and unwritten employment policies and practices involving matters such as the commencement and duration of leave, the availability of extensions, the accrual of seniority and other benefits and privileges, reinstatement, and payment under any health or temporary disability insurance or sick leave plan, formal or informal, shall be applied to disability due to pregnancy or childbirth on the same terms and conditions as they are applied to other temporary disabilities.

8.55(3) Disabilities caused or contributed to by legal abortion and recovery are, for all job-related purposes, temporary disabilities and should be treated as such under any temporary disability or sick leave plan available in connection with employment. Written and unwritten employment policies and practices involving matters such as the commencement and duration of leave, the availability of extensions, the accrual of seniority and other benefits and privileges, reinstatement, and payment under any temporary disability insurance or sick leave plan, formal or informal, shall be applied to disability due to legal abortion on the same terms and conditions as they are applied to other temporary disabilities. The employer may elect to exclude health insurance coverage for abortion from a plan provided by the employer, except where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion.

8.55(4) Where the termination of an employee who is temporarily disabled is caused by an employment policy under which insufficient or no leave is available, the termination violates the Act if it has a disparate impact on employees of one sex and is not justified by a business necessity.

161—8.56(216) Cease use of sex-segregated want ads.

8.56(1) All newspapers within the state of Iowa shall cease to use sex-segregated want ads—e.g., "Male Help Wanted," "Female Help Wanted," and "Male and Female Help Wanted" or "Men—Jobs of Interest," "Women—Jobs of Interest," and "Men and Women."

8.56(2) Any newspapers failing to comply with 8.56(1) shall be deemed in violation of the Act, Iowa Code section 216.6, and legal proceedings shall henceforth be initiated against them.

8.56(3) The commission will regard any publication of sex preference for a job to be in violation of the Act and, therefore, suggests that all Iowa newspapers refrain from publishing any sex preference which an employer in its job order may want printed.

8.56(4) The commission suggests that Iowa newspapers, instead of using sex-titled, sex-segregated want ads, use neutral want ads, e.g., "Help Wanted," "Jobs of Interest," "Positions Available."

161—8.57(216) Exception to ban on sex-segregated want ads.

8.57(1) The commission recognizes that sex may, in very limited circumstances, be a bona fide occupational qualification, e.g., a woman to be a women's fashion model. Therefore, an employer seeking to place a job order or a want ad which shows sex preference, must, by affidavit, claim that the preference is based upon bona fide occupational qualification.

8.57(2) The affidavit referred to in 8.57(1) must set out the complete basis upon which the employer believes that a person of a particular sex is required for the job the employer wishes to fill. The affidavit must also clearly state that the employer truly believes the sex preference is bona fide and that the employer, and not the newspaper or publisher of the ad, is responsible for the content of the ad.

8.57(3) Any newspaper, or other publisher which prints want ads, can publish a want ad with a sex preference if, and only if, that newspaper or publisher has received from the employer the affidavit referred to in 8.57(1) and 8.57(2). The newspaper or publisher, upon receipt of such affidavit, will submit a copy to the commission.

161—8.58 to **8.64** Reserved.

EMPLOYMENT PRACTICES IN STATE GOVERNMENT

161—8.65(216) Declaration of policy.

8.65(1) Equal opportunity and affirmative action toward its achievement is the policy of all units of Iowa state government. This policy shall apply in all areas where the state funds are expended, in employment, public service, grants and financial assistance, and in state licensing and regulation. All policies, programs and activities of state government shall be periodically reviewed and revised to ensure their fidelity to this policy.

8.65(2) Affirmative action required. All appointing authorities, and state agencies in the executive branch of government, shall abide by the requirements of Governor Robert D. Ray's Executive Order Number 15 and Iowa Code chapter 216.

Each agency shall designate an equal opportunity officer to be responsible for affirmative action policies intra-agency. Each agency shall prepare an affirmative action plan for that department in accordance with the criteria set forth in 161—8.7(216). All plans shall be subject to the review and comment of the affirmative action director of the commission. The affirmative action director shall make every effort to achieve compliance with affirmative action requirements by informal conference, conciliation and persuasion. Where failure to comply with Executive Order Number 15 results, the commission may initiate complaints against the noncomplying agencies.

8.65(3) Employment policies of state agencies. Each appointing authority shall review the recruitment, appointment, assignment, upgrading and promotion policies and activities for state employees to correct policies that discriminate on the basis of race, color, religion, sex, age, national origin or physical or mental handicap. All appointing authorities shall hire and promote employees without discrimination. Special attention shall be given to the allocation of funds for on-the-job training, the parity of civil service classes doing similar work, and the training of supervisory personnel in equal opportunity principles and procedures. Annually each appointing authority shall review their EEO-4 reports and include in their budget presentation necessary programs, goals and objectives, to improve the equal opportunity aspects of their department's employment policies. Each appointing authority shall make an annual report to the affirmative action director of the commission on persons hired, disciplined, terminated and vacancies occurring within their department.

8.65(4) State services and facilities. Every state agency shall render service to the citizens of this state without discrimination based on race, color, religion, sex, age, national origin or physical or mental handicap. No state facility shall be used in furtherance of any discriminatory practice nor shall any state agency become a party to any agreement, arrangement, or plan which has the effect of sanctioning such patterns or practices.

8.65(5) State employment services. All state agencies which provide employment referral or placement services to public or private employers shall accept job orders, refer for employment, test, classify, counsel, and train only on a nondiscriminatory basis. They shall refuse to fill any job orders designed to exclude anyone because of race, color, religion, creed, sex, national origin, age or disability. All agencies shall report to the commission any violations by state agencies and any private employers or unions which are known to persist in restrictive hiring practices.

8.65(6) State contracts and subcontracts. Every state contract for goods or services and for public works, including construction and repair of buildings, roads, bridges, and highways, shall contain a clause prohibiting discriminatory employment practices by contractors and subcontractors based on race, color, religion, creed, national origin, sex, age or disability. The nondiscrimination clause shall include a provision requiring state contractors and subcontractors to give written notice of their commitments under this clause to any labor union with which they have bargaining or other agreements. Contractual provisions shall be fully and effectively enforced and any breach of them shall be regarded as a material breach of contract.

8.65(7) State licensing and regulatory agencies. No state department, board, commission, or agency shall grant, deny, or revoke a license on the grounds of race, color, religion, creed, national origin, sex, age or disability. License, as defined in Iowa Code section 17A.2(5), includes the whole or a part of any agency permit, certificate, approval, registration, charter or similar form of permission required by

statute. Any licensee, or any applicant for a license issued by a state agency, who operates in an unlawful discriminatory manner, shall, when consistent with the legal authority and rules and regulations of the appropriate licensing or regulatory agency, be subject to disciplinary action by the appropriate agencies as provided by law, including the denial, revocation, or suspension of the license. In determining whether to apply sanctions or not, a final decision of discrimination certified to the licensing agency by the commission shall be binding upon the licensing agency.

8.65(8) State financial assistance. Race, color, religion, creed, national origin, sex, age, physical or mental disability shall not be considered as limiting factors in state-administered programs involving the distribution of funds to qualified applicants for benefits authorized by law; nor shall state agencies provide grants, loans, or other financial assistance to public agencies, private institutions or organizations which engage in discriminatory practices.

8.65(9) Reports. All state agencies in the executive branch shall report annually to the commission. Reports shall cover both internal activities and relations with the public and with other state agencies and shall contain other information as may be specifically requested by the commission in order to enable it to compile the Governor's Annual Affirmative Action Report.

8.65(10) Cooperation in investigations. All state agencies shall cooperate fully with the commission and authorized federal agencies in their investigations of allegations of discrimination.

These rules are intended to implement Iowa Code chapter 216.

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1 Effective date of 240—6.2(6) delayed 70 days by the Administrative Rules Review Committee.

2 Effective date of 8.27(6)*"a"*(2) and 8.27(6)*"b"* delayed 70 days by the Administrative Rules Review Committee at their February 11, 1988, meeting.

OBJECTION

On July 11th, 1979, the administrative rules review committee voted the following objections:

The committee objects to ARC 0192, item 7, [appearing in IAB, 4/18/79] subparagraph *6.2(6)*"a"*(2), relating to reasonable accommodation, on the grounds the provisions are beyond the authority of the commission. Subrule 6.2(6) requires that employers make "reasonable accommodation to the physical or mental handicaps of an applicant, unless it can be shown to be an "undue hardship". The above cited paragraph provides that reasonable accommodation may include:

Job restructuring, part-time or modified work schedules, acquisition or modifications of equipment or devices, the provision of readers or interpreters, and other similar actions.

It is the opinion of the committee this definition of reasonable accommodation far exceeds that which may fairly be imputed from section 601A.6(1)*"a,"* which in part declares it to be "unfair discrimination" to:

. . . refuse to hire . . . any applicant for employment . . . because of . . . disability of such applicant or employee, unless based upon the nature of the occupation. If a disabled person is qualified to perform a particular occupation by reason of training or experience, the nature of that occupation shall not be the basis of exception to the unfair or discriminating practices prohibited by this subsection.

For the purposes of the above paragraph, section 601A.2(11) defines disability as:

. . . the physical or mental condition of a person which constitutes a substantial handicap, but is unrelated to such person's ability to engage in a particular occupation.

In reading these two sections together and giving effect to each, it appears that the Civil Rights Act prohibits employment discrimination on the grounds of disability only if either of the following criteria are met: (1) The handicap is not related to that particular occupation, or (2) The applicant is qualified by training or experience to perform that occupation, even if the handicap does relate to the occupation.

The General Assembly clearly has the authority to ban any or all discrimination against disabled persons, or to require employers to make the type of "reasonable accommodation" mandated by subrule *6.2(6)*"a"*(2). However, the statute does neither. Instead the criteria listed in the above paragraph are established to prohibit discrimination only against a "qualified" disabled applicant. The statute is designed to benefit the handicapped individual who has managed to overcome his or her disability. To mandate this type of reasonable accommodation would, in the case of more affluent employers, require that the handicap be ignored, and require these employers to overcome the handicap for the applicant. If employers are to make this type of reasonable accommodation the General Assembly should so provide by law, or specifically authorize the civil rights commission to make rules on the subject. To proceed otherwise implies that an administrative agency may interpret a broadly worded statute to mean whatever the agency chooses, and reduces the statute itself to a mere tool for the transferring of law making power to administrative agencies.

The committee also objects to paragraph *6.2(6)*"b"* in its entirety, on the grounds it is unreasonable. The paragraph lists the criteria to be used in determining whether an employer must make any reasonable accommodation at all. Under the provisions of paragraph 6.2(6)*"a"*(1), employers must make the job site accessible to and usable by handicapped persons. If this type of accommodation is to be mandated at all, the burden should be equally imposed upon all employers, without singling out any specific groups to be exempt from the burden imposed.

Renumbered as 8.27(6)"a"*(2) and 8.27(6)*"b"* IAC 1/13/88.

NOTE: Iowa Code chapter 601A renumbered as chapter 216 in 1993 Iowa Code.

CHAPTER 9
DISCRIMINATION IN HOUSING

161—9.1(216) Construction of chapter.

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

a. Complaints which allege a violation of the prohibitions contained in Iowa Code section 216.8 or 216.8A;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Effect of commission processing.

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

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

1. The commission has obtained a mediation agreement with the consent of that aggrieved person regarding that alleged discriminatory housing or real estate practice, or
2. The commission has begun a contested case hearing on the record regarding that same alleged discriminatory housing or real estate practice.

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

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

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

9.4(3) *Election to proceed in district court.*

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

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

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

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

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

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

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

a. Appoint an attorney for the person, or

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

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

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

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

9.5(3) *Processing of complaint.*

a. Service. Upon the filing of a complaint:

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

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

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

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

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

d. Additional respondents.

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

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

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

9.5(4) *Probable cause determination.*

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

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

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

(3) A summary description of other pertinent records;

(4) A summary of witness statements; and

(5) Answers to interrogatories.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.5(5) *Hearing.*

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

b. Hearing time frames.

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

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

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

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

b. Notwithstanding the prohibitions and requirements with respect to disclosure of information contained in paragraph 9.5(6)*"a"* the commission will make information derived from an investigation, including the final investigative report, available to the aggrieved person and the respondent. Following completion of the investigation, the commission shall notify the aggrieved person and the respondent that the final investigative report is complete and will be provided upon request.

c. Where the commission has made a finding of no probable cause regarding a complaint alleging a discriminatory housing or real estate practice, the aggrieved person and the respondent may obtain information derived from the investigation and the final investigative report. Provided, however, that the phrase "information derived from the investigation" as used in this rule and in Iowa Code section 216.15A(2)*"f"* shall not include the contents of statements by witnesses other than the complainant or respondent.

d. Prior to a finding of either probable cause or no probable cause regarding a complaint alleging a discriminatory housing or real estate practice no access may be had to the information contained within the commission investigatory file except that:

(1) Any witness may request a copy of the witness's own statement made to the commission as part of the commission's investigation of the complaint,

(2) Any person may request copies of any information that that person sent to the commission in the course of processing the complaint,

(3) Any person may request copies of any information that the commission had previously sent to that person in the course of processing the complaint.

[**ARC 8744B**, IAB 5/5/10, effective 6/9/10]

161—9.6(216) Discovery methods in cases of alleged discrimination in housing.

9.6(1) When investigating a complaint of alleged discriminatory housing or real estate practices, the commission may, in addition to any other method of investigation authorized by law, obtain discovery by one or more of the following methods: depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission.

9.6(2) The rules providing for discovery and inspection in this chapter shall be liberally construed and shall be enforced to provide the commission with access to all relevant facts. Discovery shall be conducted in good faith, and responses to discovery requests, however made, shall fairly address and meet the substance of the request.

9.6(3) Notice of person's rights in the discovery process shall be given to the person from whom discovery is sought. This notice is sufficient if it sets out in brief the person's rights under these rules: to object to the discovery method; to seek a protective order; and to legal counsel.

9.6(4) A rule in this chapter requiring a matter to be under oath may be satisfied by an unsworn written statement in substantially the following form: "I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

_____ _____"

Date Signature

161—9.7(216) Scope of discovery. Unless otherwise limited by order of the presiding officer for discovery in accordance with these rules, the scope of discovery is as follows:

9.7(1) *In general.* The commission may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending investigation, whether it relates to the claim or defense of any party, including the existence, description, nature, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not grounds for objection that the information sought will be inadmissible at a trial or contested case hearing if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

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

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

(1) The identity and location of persons having knowledge of discoverable matters; and

(2) Any matter that bears materially upon a claim or defense asserted by any party.

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

(1) The party knows that the response was incorrect when made; or

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

161—9.8(216) Protective orders.

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

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

(1) That the discovery not be had;

(2) That the discovery may be had only on specified terms and conditions, including a designation of the time or place;

(3) That the discovery may be had only by a method of discovery other than that selected by the commission;

(4) That certain matters not be inquired into, or that the scope of the discovery be limited to certain matters;

(5) That discovery be conducted with no one present except persons designated by the presiding officer for discovery;

(6) That a deposition after being sealed be opened only by order of a court, a commission contested case presiding officer, or the presiding officer for discovery;

(7) That a trade secret or other confidential research, development, or commercial information not be disclosed or be disclosed only in a designated way;

(8) That the parties simultaneously file specified documents or information enclosed in sealed envelopes to be opened as directed by the presiding officer for discovery.

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

(1) The discovery sought is unreasonably cumulative or duplicative, or is obtainable from some other source that is more convenient, less burdensome, or less expensive;

(2) The commission has had ample opportunity by discovery in the action to obtain the information sought; or

(3) The discovery is unduly burdensome or expensive, taking into account the needs of the case, the amount in controversy, limitations on the objecting party's resources, and the importance of the issues at stake in the investigation.

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

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

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

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

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

161—9.9(216) Interrogatories.

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

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

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

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

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

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

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

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

161—9.10(216) Requests for admission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.16(2) *Failure to comply with order.*

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

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

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

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

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

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

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

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

a. The request was held objectionable pursuant to rule 161—9.10(216),

b. The admission sought was of no substantial importance,

c. The party failing to admit had reasonable ground to believe that the party might prevail on the matter, or

d. There was other good reason for the failure to admit.

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

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

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

161—9.17(216) Depositions upon oral examination.

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

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

9.17(3) *Place of deposition.*

a. Oral depositions may be taken only within this state.

b. If the deponent is a party or the officer, partner or managing agent of a party which is not a natural person, the deponent shall be required to submit to examination in Polk County, unless otherwise ordered by the presiding officer for discovery.

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

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

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

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

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

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

161—9.18(216) Notice for oral deposition.

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

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

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

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

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

161—9.19(216) Conduct of oral deposition.

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

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

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

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

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

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

161—9.20(216) Reading and signing depositions.

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

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

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

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

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

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

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

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

161—9.23(216) Deposition subpoena.

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

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

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

161—9.25(216) Irregularities and objections.

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

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

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

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

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

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

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

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CHAPTER 10
DISCRIMINATION IN PUBLIC ACCOMMODATIONS

[Prior to 1/13/88, see Civil Rights 240—Ch 7]

161—10.1(216) Statement of purpose. The commission's purpose in adopting these rules is to provide guidelines on what actions or activities may produce a discriminatory impact in public accommodations.

161—10.2(216) Discrimination prohibited. No person shall be discriminated against on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability by any public accommodation by:

10.2(1) Providing any disposition, service, financial aid, or benefit to an individual which is different, or is provided in a different manner, from that provided to other members of the general public, except to reasonably accommodate a member of the protected classes who otherwise might be totally precluded from receiving a benefit, access to, or participation in a program.

10.2(2) Subjecting any individual to segregation or separate treatment in any matter related to that individual's receipt of any disposition, service, financial aid, or benefit provided to other members of the general public.

10.2(3) Restricting an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any disposition, service, financial aid, or benefit provided to other members of the general public.

10.2(4) Treating an individual differently from others in determining whether that individual satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any disposition, service, financial aid, function, or benefit available to other members of the general public.

10.2(5) Denying an individual an opportunity to participate in a program through the provision of service or otherwise afford that individual an opportunity to do so which is different from that afforded to other members of the general public.

[**ARC 8744B**, IAB 5/5/10, effective 6/9/10]

These rules are intended to implement Iowa Code chapter 216.

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[1] Effective date of Ch 7 delayed by the Administrative Rules Review Committee 70 days.
Effective date of 7.2(1) and 7.3 delayed by the Administrative Rules Review Committee until 45 days after convening of the next General Assembly.

CHAPTER 11
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

161—11.1(17A,22,216) Definitions. As used in this chapter:

"Agency" means the Iowa civil rights commission.

"Confidential record" means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the agency is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Custodian" means the executive director, or a person lawfully delegated authority by the executive director to act for the agency in implementing Iowa Code chapter 22.

"Open record" means a record other than a confidential record.

"Personally identifiable information" means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

"Record" means the whole or a part of a "public record" as defined in Iowa Code section 22.1.

"Record system" means any group of records under the control of the agency from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

161—11.2(17A,22,216) Statement of policy. This chapter implements Iowa Code section 22.11 and chapter 216 by establishing agency policies and procedures for the maintenance of records. The purpose of this chapter is to facilitate public access to open records. It also seeks to facilitate sound agency determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This agency is committed to the policies set forth in Iowa Code chapter 22; agency staff shall cooperate with members of the public in implementing the provisions of that chapter.

161—11.3(17A,22,216) Requests for access to records.

11.3(1) *Location of record.* A request for access to a record should be directed to the Iowa civil rights commission or the particular agency office where the record is kept. The request shall be directed to the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-1004. If a request for access to a record is misdirected, agency personnel will promptly forward the request to the appropriate person within the agency.

11.3(2) *Office hours.* Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m., Monday through Friday, except legal holidays.

11.3(3) *Request for access.* Requests for access to open records may be made in writing or in person. The office may also accommodate telephone requests where appropriate. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

11.3(4) *Response to requests.* Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a

confidential record, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 161—11.4(17A,22,216) and other applicable provisions of law.

11.3(5) *Security of record.* No person may, without permission from the custodian, search or remove any record from agency files. Examination and copying of agency records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

11.3(6) *Copying.* A reasonable number of copies of an open record may be made in the agency's office. If photocopy equipment is not available in the agency office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

11.3(7) *Fees.*

a. When charged. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published materials and for photocopies of records shall be prominently posted in agency offices. Copies of records may be made by or for members of the public on agency photocopy machines or from electronic storage systems at cost as determined and posted in agency offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

c. Supervisory fee. An hourly fee may be charged for actual agency expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one-half hour. The custodian shall prominently post in agency offices the hourly fees to be charged for supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of an agency clerical employee who ordinarily would be appropriate and suitable to perform this supervisory function.

d. Search fees. If the request requires research or if the record or records cannot reasonably be readily retrieved by the office, the requester will be advised of this fact. Reasonable search fees may be charged where appropriate. In addition, all costs for retrieval and copying of information stored in electronic storage systems may be charged to the requester.

e. Advance deposits.

(1) When the estimated total fee chargeable under this subrule exceeds $25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require advance payment of the full amount of any estimated fee before the custodian processes a new request from that requester.

[**ARC 8733B**, IAB 5/5/10, effective 6/9/10]

161—11.4(17A,22,216) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law may authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 161—11.3(17A,22,216).

11.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

11.4(2) *Requests.* The custodian may require that a request to examine and copy a confidential record be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

11.4(3) *Notice to subject of record and opportunity to obtain injunction.* After the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified

in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such a confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose.

11.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

a. The name and title or position of the custodian responsible for the denial; and

b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

11.4(5) *Request granted.* When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

161—11.5(17A,22,216) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

11.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

11.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as such a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

A person filing such a request shall, if possible, accompany the request with a copy of the record in question from which those portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the agency by the person requesting such confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

11.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the agency does not request that it be withheld from public inspection under Iowa Code section 22.7(3) or 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

11.5(4) *Timing of decision.* A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

11.5(5) *Request granted or deferred.* If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a

request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

11.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester, the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record need not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

161—11.6(17A,22,216) Procedure by which additions, dissents, or objections may be entered into certain records. Except as otherwise provided by law, a person may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that person. However, this does not authorize a person who is a subject of such a record to alter the original copy of that record or to expand the official record of any agency proceeding. Requester shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian. The request to review a written statement must be dated and signed by requester, and shall include the current address and telephone number of the requester or the requester's representative.

161—11.7(17A,22,216) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, a person who is the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records that may be disclosed, and the particular person or class of persons to whom the record may be disclosed and, where applicable, the time period during which the record may be disclosed. The person who is the subject of the record and, where applicable, the person to whom the record is to be disclosed, may be required to provide proof of identity. Additional requirements may be necessary for special classes of records. Appearance of counsel on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the agency to disclose records about that person to the person's attorney.

161—11.8(17A,22,216) Notice to suppliers of information. When the agency requests a person to supply information about that person, the agency shall notify the person of the use that will be made of the information, which persons outside the agency might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means. Notice need not be given in connection with discovery requests in litigation or administrative proceedings, subpoenas, investigations of possible violations of law, or similar demands for information.

161—11.9(17A,22,216) Disclosures without the consent of the subject.

11.9(1) Open records are routinely disclosed without the consent of the subject.

11.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, may generally occur without notice to the subject:

a. For a routine use as defined in rule 161—11.10(17A,22,216) or in any notice for a particular record system.

b. To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record; provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if any authorized representative of such government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known address of the subject.

e. To the legislative services agency under Iowa Code section 2A.3.

f. To the citizens' aide/ombudsman under Iowa Code section 2C.9.

g. Disclosures in the course of employee disciplinary proceedings.

h. In response to a court order or subpoena.

161—11.10(17A,22,216) Routine use.

11.10(1) Defined. "Routine use" means the disclosure of a record without the consent of the subject or subjects for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

11.10(2) To the extent allowed by law, the following uses may be considered routine uses of all agency records:

a. Disclosure to those officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may upon request of any officer or employee, or on the custodian's initiative, determine what constitutes legitimate need to use confidential records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Disclosure to the agency or officer which this office is advising or representing in the matter in question or to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the agency.

d. Transfers of information within the agency, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.

e. Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the agency is operating a program lawfully.

f. Any disclosure specifically authorized by the statute under which the record was collected or maintained.

161—11.11(17A,22,216) Consensual disclosure of confidential records.

11.11(1) *Consent to disclosure by a subject individual.* The subject may consent in writing to agency disclosure of confidential records as provided in rule 161—11.7(17A,22,216).

11.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the agency may to the extent permitted by law be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

161—11.12(17A,22,216) Availability of records.

11.12(1) *General.* Agency records are open for public inspection and copying unless otherwise provided by rule or law. The office also has possession of records which may be open records but which are copies of materials from another agency, which have been filed in judicial or administrative proceedings, or which are available in the state law library. This office will often refer persons to the originating agency, the clerk of the appropriate court, or the law library for those records. This is consistent with the functions of those entities, ensures that the requester get a clean official copy of the record, and protects the integrity of attorney files against unintended disclosures of confidential information.

11.12(2) *Confidential records.* The following records may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. Tax records made available to the agency. (Iowa Code sections 422.72,422.20)

b. Records which are exempt from disclosure under Iowa Code section 22.7.

c. Minutes of closed meetings of a government body. (Iowa Code section 21.5(4))

d. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3 (1)*"d."*

e. Those portions of agency staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by agency staff in auditing, in making investigations, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would:

(1) Enable law violators to avoid detection;

(2) Facilitate disregard of requirements imposed by law; or

(3) Give a clearly improper advantage to persons who are in an adverse position to the agency. (Iowa Code sections 17A.2, 17A.3, 216.15)

f. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10, 622.11, Iowa R.C.P. 122(c), Fed. R.Civ.P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.

g. Records collected or generated by Iowa civil rights commission staff or commissioners relating to any step in the civil rights complaint process which contain personally identifiable information.

h. Any other records made confidential by law. (Iowa Code section 216.15)

11.12(3) *Authority to release confidential records.* The agency may have discretion to disclose some confidential records which are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect these records withheld from inspection under a statute which authorizes limited or discretionary disclosure as provided in rule 161—11.4(17A,22,216). If the agency initially determines that it will release such records, the agency may, where appropriate, notify interested persons and withhold the records from inspection as provided in subrule 11.4(3).

161—11.13(17A,22,216) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the agency by personal identifier in record systems as defined in rule 161—11.1(17A,22,216). Unless otherwise stated, the authority for this office to maintain the record is provided by Iowa Code chapter 216, the statutes governing the subject matter of the record, and the enabling statutes of the agency client, where applicable. The record systems maintained by the agency shall include but are not limited to the following:

11.13(1) *Investigatory files.* These files or records contain information collected or generated by Iowa civil rights commission staff or commissioners relating to any step in the complaint process beginning with the consideration or contemplation of filing a complaint up to the issuance of a notice of public hearing. Most of these records are paper files. However, some case management records and other records are in computer form. Those files are commonly indexed by the name of the opposing party. Some files are indexed by subject matter, witness, agency or other category.

11.13(2) *Litigation files.* These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include pleadings, briefs, depositions, discovery material, docket sheets, documents, general correspondence, attorney-client correspondence, attorneys' notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. Most of these records are paper files. However, some case management records and other records are in computer form. The files are generally maintained by division and are commonly indexed by the name of the opposing party. Some files are indexed by subject matter, witness, agency, or other category. The files contain materials which are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and other documents filed in litigation should obtain these from the clerk of the appropriate court which maintains the official copy.

11.13(3) *Records.* State of Iowa files are a subpart of the complaint file system and contain general information on an individual or business including correspondence, investigative information, agency subpoenas, demands for information and responses. Work product information contained in the state of Iowa file is considered confidential. The records are subject to the same confidentiality provisions as are complaint files.

11.13(4) *Personnel files.* The Iowa civil rights commission and individual divisions maintain files containing information about employees and applicants for positions with the agency. The files contain payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship. Some of this information is confidential under Iowa Code section 22.7(11).

161—11.14(17A,22,216) Other groups of records. This rule describes groups of records maintained by the agency other than record systems as defined in rule 161—11.1(17A,22,216). The records listed may contain information about individuals. Unless otherwise designated, the authority for this office to maintain the record is provided by Iowa Code chapter 216, the statutes governing the subject matter of the record. Those privileges may render some or all of the following information confidential whether or not asserted in the description of the record. All records are stored both on paper and in automated data processing systems unless otherwise noted.

11.14(1) *Administrative records.* This includes documents concerning budget, property inventory, purchasing, yearly reports, office policies for employees, time sheets, printing and supply requisitions.

11.14(2) *Publications.* The office receives a number of books, periodicals, newsletters, government documents, etc. These materials would generally be open to the public but may be protected by copyright law. Most publications of general interest are available in the state law library.

11.14(3) *Office publications.* This office issues a variety of materials including press releases, statistical reports, Iowa civil rights commission case reports and annual reports.

11.14(4) *Rule-making records.* Official documents executed during the promulgation of agency rules and public comments are available for public inspection.

11.14(5) *Office manuals.* Information in office manuals such as the investigator handbook are available for public inspection.

11.14(6) *All other records.* Records are open if not exempted from disclosure by law.

161—11.15(17A,22,216) Data processing systems. The data processing systems used by the agency compare personally identifiable information in one record system with personally identifiable information in another record system.

161—11.16(17A,22,216) Applicability. This chapter does not:

1. Require the agency to index or retrieve records which contain information about individuals by that person's name or other personal identifier.

2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.

3. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the agency which are governed by the regulations of another agency.

4. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs, unless otherwise provided by law or agreement.

5. Make available records compiled in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations.

6. Make available to the general public records which would otherwise not be available under Iowa Code section 216.15(4).

161—11.17(17A,22,216) Access to file information. The disclosure of information whether a change has been filed or not, or revealing the contents of any file is prohibited except in the following circumstances:

11.17(1) If a final decision per 161—subrule 2.1(10) has been reached, a party or a party's attorney may, upon showing that a petition appealing the commission action has been filed, have access to the commission's case file on that complaint.

11.17(2) If a case has been approved for public hearing and the notice of hearing has been issued, any party or party's attorney may have access to file information through prehearing discovery measures provided in 161—4.6(216). In addition, file information may be sought pursuant to Iowa Code subsection 17A.13(2).

11.17(3) If a decision rendered by the commission in a contested case has been appealed, any party or party's attorney may, upon showing that the decision has been appealed, have access to the commission's case file on that complaint.

The fact that copies of documents related or gathered during an investigation of a complaint are introduced as evidence during the course of a contested case proceeding does not affect the confidential status of all other documents within the file which are not introduced as evidence.

11.17(4) If the commission has issued a right-to-sue letter per 161—subrule 3.10(3), a party or party's attorney may have access to the commission's case file on that complaint.

11.17(5) Only upon written notification, from an attorney or a party, that the attorney represents that party may the attorney then obtain access to the commission case file on the same terms as that party.

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[1] Effective date of 161—11.17(2), 11.17(4) and 11.17(5) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 1993; delayed until adjournment of the 1994 Session of the General Assembly by this Committee May 11, 1993.

CHAPTER 15
MISCELLANEOUS PROVISIONS
[Prior to 1/13/88, see Civil Rights 240—Ch 11]

161—15.1(216) Partial invalidity. If any provision of commission rules shall be held invalid, the remainder of the rules shall not be affected thereby. The invalidity of any of the rules with respect to a particular person or under particular circumstances shall not affect their application to other persons or different circumstances.

161—15.2(216) Availability of rules. Copies of commission rules shall be available to the public on request.

161—15.3(17A,ExecOrd11) Waiver of requirements imposed by commission rule.

15.3(1) *Filing of a request for waiver or variance.* Any person may file a request for waiver or variance of an administrative rule of the civil rights commission by writing a proper request which is received by Executive Director, Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319-1004. All requests for waiver or variance of an administrative rule must be in writing and meet all requirements set out in paragraph 15.3(2)*"a."* A request for a waiver is filed by any of the methods listed in rule 161—3.5(216). The date a request for waiver is filed is governed by 161—subrule 3.5(4). The commission shall provide the requester with a file-stamped copy of the request if the requester provides an extra copy for this purpose.

15.3(2) *Form of request.*

a. Required contents. A request for waiver or variance of a rule must:

(1) Prominently state on its face that it is a request for a waiver or variance of an administrative rule; and

(2) State the name and address of the entity or person for whom a waiver or variance is requested; and

(3) Describe or give the citation of the specific rule for which a waiver or variance is requested; and

(4) State the specific waiver or variance requested.

The commission shall not process a filing as a request for a waiver or variance if that filing does not conform to the requirements of this paragraph.

b. Suggested contents. In addition, a request for waiver or variance of a rule should also:

(1) State all relevant facts that the requester believes would justify a waiver or variance.

(2) State the reasons the requester believes will justify a waiver or variance.

(3) State the history of the commission's action relative to the requester. If the request is in connection with a complaint of discrimination on file with the commission, the requester should identify the complaint at issue including, if possible, the complaint number.

(4) State any information regarding the commission's treatment of similar cases, if known.

(5) State the name, address and telephone number of any person inside or outside state government who would be adversely affected by the grant of the request or who otherwise possesses knowledge of the matter with respect to the waiver or variance request.

15.3(3) *Procedure for evaluating requests for waiver.*

a. Service of request. Within 30 days after the receipt of a request for waiver or variance of an administrative rule, the commission shall provide a copy to all persons who are required to receive one by a provision of law. The commission may also provide a copy of the request to those individuals whom the requester has identified as being adversely affected by a grant of the request. In the case of a request made in connection with a complaint of discrimination on file with the commission, the commission shall provide a copy of the request to all other parties in the case. Service may occur by regular mail. If necessary for maintenance of the confidentiality of a commission investigation, information may be redacted from a request for variance before the request is provided to persons other than the requester.

b. Decision maker for request. The decision whether to grant a request for waiver or variance shall be made either by the executive director or upon a vote of the commissioners. If the request is

made in connection with a complaint of discrimination on file with the commission, any discussion by the commissioners of the request for waiver may be in closed session.

c. Investigation of allegations. The decision maker or a designated member of the commission staff may conduct an investigation into any factual issue which is relevant to the request for a waiver or variance. A refusal by the requester to cooperate in this investigation may be grounds to deny the request for waiver or variance. In the case of a request made in connection with a complaint of discrimination, if any party to the complaint refuses to cooperate in the investigation, the decision maker may infer that the requested information would be adverse to the uncooperative party.

d. Time frame for decision on request. The commission shall render a decision on a request for waiver or variance of a rule within 120 days of receipt of the request. During this period the commission may extend the time for rendering a decision by notifying all persons who were notified of the request pursuant to paragraph 15.3(3)*"a"* that the time for rendering a decision has been extended. This notice shall include a new time frame for rendering the decision. Failure to render a decision or extend the time for rendering a decision within the required period shall be deemed a denial of the request.

e. Notification of decision. The commission shall send any decision rendered concerning the request for waiver or variance to all persons who were notified of the request pursuant to paragraph 15.3(3)*"a."*

f. Form of grant of request. Any waiver or variance shall be the narrowest exception possible to the provisions of the rule. A waiver or variance shall not be permanent unless the requester has shown that a temporary waiver or variance is impracticable. The commission may renew a temporary waiver or variance without a request if the commission finds that the factors of paragraph 15.3(4)*"b"* remain valid.

15.3(4) *Standard for evaluating request for waiver.*

a. Burden of persuasion. The burden of persuasion rests with the person who requests from the commission a waiver or variance of a rule.

b. Standard. A request for a waiver or variance shall be evaluated based on the unique, individual circumstances set out in the request. A waiver or variance may be granted only if the decision maker finds clear and convincing evidence that:

(1) The application of the rule would pose an undue hardship on the person for whom the waiver or variance is requested; and

(2) The waiver or variance from the requirements of a rule in the specific case would not prejudice the substantial legal rights of any person; and

(3) The provisions of a rule subject to a request for a waiver or variance 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 a means other than that prescribed in the particular rule for which the waiver or variance is requested; and

(5) Granting the request would not waive or vary any requirement created or duty imposed by statute.

15.3(5) *Exceptions to waiver.*

a. Waiver in contested cases. This rule does not apply to any request for a waiver or variance of a rule which is made in connection with a contested case before the commission. Waiver or variance requests made in connection with a contested case are governed by rule 161—4.29(17A).

b. Not applicable to this rule. No person may request a waiver or variance from the requirements of this rule.

c. Requests by commission officials. No commissioner, commission staff member or other commission official may file a request for a waiver of a requirement placed upon that individual as part of that individual's official duties.

d. Time requirements. This rule does not authorize the commission to waive or vary any time requirement of an administrative rule.

e. No effect on case status. In the case of a request made in connection with a complaint of discrimination on file with the commission, the commission may not grant a request for waiver or variance if this would either close a case which was open at the time of the request or reopen a case

which was closed at the time of the request. The reopening provisions of rule 161—3.16(216), however, shall apply.

15.3(6) *Public inspection of waiver requests.* All waiver or variance requests and responses shall be indexed by administrative rule number and available to members of the public for inspection at the offices of the Civil Rights Commission, Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319. Identifying information concerning any person, including parties to complaints on file, may be withheld by the commission in order to protect the confidentiality of case-related information as required by 2009 Iowa Code Supplement section 216.15(5).

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IOWA FINANCE AUTHORITY[265]

[Prior to 7/26/85, Housing Finance Authority[495]]
[Prior to 4/3/91, Iowa Finance Authority[524]]

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265—12.1(16) Qualified allocation plan. The qualified allocation plan entitled Iowa Finance Authority Low-Income Housing Tax Credit Program 2010 Qualified Allocation Plan shall be the qualified allocation plan for the allocation of 2010 low-income housing tax credits consistent with IRC Section 42 and the applicable Treasury regulations and Iowa Code section 16.52. The qualified allocation plan includes the plan, application, and the application instructions. The qualified allocation plan is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2). The qualified allocation plan does not include any amendments or editions created subsequent to October 7, 2009.
[**ARC 8266B**, IAB 11/4/09, effective 12/9/09]

265—12.2(16) Location of copies of the plan. The qualified allocation plan can be reviewed and copied in its entirety on the authority's Web site at http://www.iowafinanceauthority.gov. Copies of the qualified allocation plan, application, and all related attachments and exhibits shall be deposited with the administrative rules coordinator and at the state law library and shall be available on the authority's Web site. The plan incorporates by reference IRC Section 42 and the regulations in effect as of October 7, 2009. Additionally, the plan incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and information about these statutes, regulations and rules is on the authority's Web site.
[**ARC 8266B**, IAB 11/4/09, effective 12/9/09]

265—12.3(16) Compliance manual. The Low Income Housing Tax Credit Program Compliance Monitoring Manual, dated January 1, 2010, is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).
[**ARC 7700B**, IAB 4/8/09, effective 3/19/09; **ARC 7891B**, IAB 7/1/09, effective 8/5/09; **ARC 8723B**, IAB 5/5/10, effective 6/9/10]

265—12.4(16) Location of copies of the manual. The compliance manual can be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the compliance manual shall be deposited with the administrative rules coordinator and at the state law library. The compliance manual incorporates by reference IRC Section 42 and the regulations in effect as of October 31, 2009. Additionally, the compliance manual incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and links to these statutes, regulations and rules are on the authority's Web site. Copies are available from the authority upon request at no charge.
[**ARC 7700B**, IAB 4/8/09, effective 3/19/09; **ARC 7891B**, IAB 7/1/09, effective 8/5/09; **ARC 8723B**, IAB 5/5/10, effective 6/9/10]

These rules are intended to implement Iowa Code section 16.52.

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[Filed ARC 8723B (Notice ARC 8508B, IAB 2/10/10), IAB 5/5/10, effective 6/9/10]

CHAPTER 30
QUALIFIED MIDWESTERN DISASTER AREA BOND ALLOCATION

265—30.1(16) General. The governor has appointed the executive director of the Iowa finance authority as the governor's designee responsible for administration of the law which establishes procedures for allocating the authority to issue up to a specified amount of qualified midwestern disaster area ("MDA") bonds as defined in Section 1400N of the Internal Revenue Code, as amended by the Heartland Disaster Tax Relief Act ("Act") of 2008. The Act was passed in response to the disasters attributable to the severe storms, tornadoes, and flooding that gave rise to any of the presidential declarations of a major disaster on or after May 20, 2008, and before August 1, 2008, under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and that were determined by the President to warrant individual or individual and public assistance from the federal government under such Act with respect to damages attributable to such severe storms, tornadoes, or flooding (collectively, "disasters"). The Act limits the aggregate face amount of bonds that may be designated as MDA bonds. The role of the governor's designee is to allocate on behalf of particular projects authorization to issue specified allotments of MDA bonds from the total aggregate face amount permitted under the Act. The authority to issue up to a specified face amount of MDA bonds, as allocated to a particular project pursuant to this chapter, may be referred to herein as an "allotment." Procedures set out in the Act and in these rules shall be followed in allocating allotments for the various purposes authorized by the Act. The allotments shall be allocated among all eligible applicants for those various purposes in accordance with the Act, Executive Order Number 9, and these rules.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

265—30.2(16) Forms. Information and forms necessary for compliance with provisions of the law are available upon request from the Iowa Finance Authority, 2015 Grand Avenue, Des Moines, Iowa 50312. The telephone number of the authority is (515)725-4900. Information and forms are also available at www.iowafinanceauthority.gov.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

265—30.3(16) Eligibility for allocation.

30.3(1) In the case of a project involving a private business use (as defined in Section 141(b)(6) of the Internal Revenue Code), to be eligible for an allotment, the applicant must certify that the entity using the property either:

a. Suffered a loss in a trade or business attributable to the disasters; or

b. Is a person replacing a trade or business with respect to which another person suffered such a loss.

30.3(2) In the case of a project relating to public utility property (as defined in Section 168(i)(10) of the Internal Revenue Code), to be eligible for an allotment, the applicant must certify that the project involves repair or reconstruction of public utility property damaged by the disasters.

30.3(3) For a project to be eligible for an allotment as a qualified mortgage issue, the applicant must certify that 95 percent or more of the net proceeds (as defined in Section 150(a)(3) of the Internal Revenue Code) of the issue are to be used to provide financing for mortgagors who suffered damages to their principal residences attributable to the disasters.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09; **ARC 8548B**, IAB 2/24/10, effective 2/4/10; **ARC 8724B**, IAB 5/5/10, effective 6/9/10]

265—30.4(16) Allocation limit and Iowa department of economic development set-aside.

30.4(1) Per-applicant cap; set-aside.

a. Through December 31, 2011, allotments shall be limited to not more than $200 million per applicant, with any related party, as defined under Section 267 of the Internal Revenue Code, being included within the meaning of applicant for the application of subrule 30.4(1). This limitation shall not apply to any project recommended by the Iowa department of economic development.

b. Through December 31, 2011, an amount of $300 million shall be set aside and made available to applicants selected by the Iowa department of economic development. The director of the Iowa

department of economic development shall notify the authority in writing of the name of each applicant that is to receive an allotment under subrule 30.4(1) and the amount allotted to each applicant. Promptly upon receipt of this written notice, the authority shall award the designated allotment to said applicant.

c. Following December 31, 2011, all unallocated allotments under paragraph 30.4(1)*"b"* shall be available to all eligible projects. Following December 31, 2011, the per-applicant cap set forth in paragraph 30.4(1)*"a"* shall not apply.

30.4(2) Subject to subrule 30.4(1) above, allotments shall be allocated among eligible applications on the basis of the chronological order of receipt of applications. Chronological order of receipt shall be determined by the date, hour and minute indicated by the time stamp as affixed to the application at the offices of the governor's designee.

30.4(3) All applications that are received by the governor's designee on or prior to December 22, 2008, pursuant to the provisions of rule 265—30.5(16) shall be considered simultaneously received at the opening of business on December 22, 2008, and the same date, hour and minute shall be stamped on each application so received. If the total amount of allotments requested in all of the applications received for projects located in a particular county exceeds the total amount that may be allocated for such county, the applications will be considered for allocation in the order determined pursuant to the procedures set forth in subrule 30.4(4).

30.4(4) In order to determine the order of allocation of the allotments to two or more applications that are simultaneously received pursuant to subrule 30.4(3) and for which there is insufficient capacity to allocate to each the full allotment requested, each such application shall be assigned a preference number determined by a random drawing to be conducted at the Iowa finance authority offices within one week following the receipt of the applications. The authority shall notify the affected applicants in writing and shall post a notice at its offices of the time and place of the drawing not less than three days prior to the scheduled drawing. Any person desiring to attend and witness the drawing and assigning of preference numbers may do so. Each application shall be assigned an identification code that shall be written on the outside of the sealed envelope containing the application. The identification codes shall be written on strips of paper and placed in individual envelopes and sealed. The sealed envelopes containing identification codes shall be placed in a container, mixed, and drawn from the container at random by a member of the authority's staff. The application that corresponds to the identification code that is drawn first shall be placed first on the list of applicants to receive an allotment. The application that corresponds to the identification code that is selected second shall be placed second on the list, and so forth. Drawings shall continue until all applications are assigned a place on the list of applications received.

30.4(5) The governor's designee shall maintain a list of applications for MDA bonds. Any applications that are deemed to be simultaneously received shall be listed in the order of preferences established pursuant to subrule 30.4(4). Applications received after December 22, 2008, shall be added to the appropriate list depending upon the subject of the application in the chronological order received.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09; **ARC 8548B**, IAB 2/24/10, effective 2/4/10; **ARC 8724B**, IAB 5/5/10, effective 6/9/10]

265—30.5(16) Application for allocation.

30.5(1) An applicant must produce to the governor's designee an inducement resolution adopted by a governmental entity authorized to issue bonds.

30.5(2) An applicant or beneficiary, or the duly authorized agent of an applicant or beneficiary, must make an application by filing the form entitled "Application for Midwestern Disaster Area Bonds" available from the governor's designee for the allocation of an allotment.

30.5(3) Applications may be submitted to the Iowa finance authority offices at any time. All applications received on or prior to December 22, 2008, will be deemed received simultaneously as of the date, hour and minute of the opening of business of the Iowa finance authority on the first business day immediately following December 22, 2008.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

265—30.6(16) Certification of allocation. Upon receipt of a completed application, the governor's designee shall promptly certify to the applicant the amount of the allotment allocated to the project for

which the application was submitted. Subject to subrule 30.4(1), the governor's designee shall continue to allocate allotments for eligible projects until the allotments allocated equal the maximum aggregate face amount that may be designated as MDA bonds under the Act or until there are no more applications, whichever occurs first. If the remaining allotment capacity is not sufficient to fully fund an application which is next in order for allocation, the governor's designee shall notify the applicant of the amount that is available and the applicant shall have the option to take what is available within five calendar days of receiving notice of availability. If the applicant does not notify the governor's designee of its decision to take the available allocation within five calendar days of receiving notice of that option, an allotment shall be offered to the next application on the list under the same conditions. If the partial allocation is accepted, the applicant shall submit a new application for an additional allotment and that application will be added to the bottom of the list in the chronological order of its receipt. If the bonds are issued and delivered prior to the expiration date of the allocation, then the applicant or the applicant's attorney shall within ten days following the issuance and delivery of the bonds notify the governor's designee by filing the form captioned "Notice of Issuance and Delivery of Bonds."
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09; **ARC 8548B**, IAB 2/24/10, effective 2/4/10; **ARC 8724B**, IAB 5/5/10, effective 6/9/10]

265—30.7(16) Expiration of allocations. An allocation of an allotment pursuant to this chapter shall remain valid for 150 days from the date of allocation. If the sale of bonds for which an allocation was made has not closed within such time, the allocation shall expire and the allotment shall revert to the governor's designee to be reallocated, if possible; provided, however, that if the 150th day following the date of allocation is a Saturday, Sunday, or any day on which the offices of the state banking institutions or savings and loan associations in the state are authorized or required to close, the expiration date shall be extended to the first day thereafter which is not a Saturday, Sunday or previously described day. All MDA bonds must be issued prior to January 1, 2013.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

265—30.8(16) Resubmission of expired allocations. If an allocation expires, the applicant may resubmit its application for the same project or purpose. However, the resubmitted application shall be treated as a new application, and preference, priority or prejudice shall not be given to the application or the applicant as a result of the prior application.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

265—30.9(16) Application and allocation fees. The Iowa finance authority may set and charge reasonable fees for providing administrative assistance with regard to the filing of applications and the allocation of the qualified MDA bond allotments in accordance with these rules.
[**ARC 7703B**, IAB 4/8/09, effective 5/13/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r,"* the Heartland Disaster Tax Relief Act of 2008, and Executive Order Number 9.

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[Filed ARC 8724B (Notice ARC 8549B, IAB 2/24/10), IAB 5/5/10, effective 6/9/10]

CHAPTER 33
WATER QUALITY FINANCIAL ASSISTANCE PROGRAM

265—33.1(16,83GA,SF376) Overview.

33.1(1) *Statutory authority.* The authority to provide financial assistance to communities for water quality and wastewater improvement projects is provided by 2009 Iowa Acts, Senate File 376, section 13(4). The water quality financial assistance fund shall consist of funds appropriated from the revenue bonds capital fund created in 2009 Iowa Acts, Senate File 376, section 2.

33.1(2) *Purpose.* The purpose of the program shall be to provide grants to enhance water quality and to assist communities with water and wastewater improvement projects. Financial assistance under the program shall be used to provide additional assistance to communities receiving loans from the Iowa water pollution control works and drinking water facilities financing program.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.2(16,83GA,SF376) Definitions.

"Authority" or *"IFA"* means the Iowa finance authority as established by chapter 16 of the Code of Iowa.

"Community" means a city, county, sanitary district, water district, state agency, or other governmental body or corporation empowered to provide sewage collection and treatment services, or any combination of two or more of the governmental bodies or corporations acting jointly, in connection with a project.

"Department" or *"DNR"* means the Iowa department of natural resources.

"Director" means the director of the authority.

"Program" means the water quality financial assistance program created in 2009 Iowa Acts, Senate File 376, section 13(4).

"Recipient" means the entity receiving funds from the program.

"SRF" means the Iowa water pollution control works and drinking water facilities financing program, which is jointly administered by IFA pursuant to Iowa Code section 16.131 as amended by 2009 Iowa Acts, House File 281, and DNR pursuant to Iowa Code section 455B.294.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.3(16,83GA,SF376) Small community assistance fund.

33.3(1) *Program fund.* Of the amount appropriated, $35 million shall be allocated to the small community assistance fund. The maximum award for a recipient under the small community assistance fund shall be $2 million.

33.3(2) *Project eligibility.* Financial assistance shall only be available under the program for projects that are also receiving funding from the SRF.

33.3(3) *Eligible applicants.* Only communities with a population of 10,000 or less, as determined by the most recent federal census, may apply for the small community assistance fund.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.4(16,83GA,SF376) Large community assistance fund.

33.4(1) *Program fund.* Of the amount appropriated, $20 million shall be allocated to the large community assistance fund. The maximum award for a recipient under the large community assistance fund shall be $100 per capita. For purposes of these rules, the population of a community shall be assumed to be the United States Census Bureau's 2008 population estimate for that community.

33.4(2) *Project eligibility.* Eligible projects are those projects that are also receiving funding from the SRF.

33.4(3) *Eligible applicants.* Only communities with a population of more than 10,000, as determined by the most recent federal census, may apply for the large community assistance fund.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 8510B**, IAB 2/10/10, effective 1/14/10; **ARC 8725B**, IAB 5/5/10, effective 6/9/10]

265—33.5(16,83GA,SF376) Project priority.

33.5(1) *Priority for all projects.* Priority shall be given to projects that will provide significant improvement to water quality in the relevant watershed; this criterion will be determined by the score given to a project by the department pursuant to the project priority rating system used for the water pollution control state revolving fund set forth in 567—Chapter 91, Iowa Administrative Code. For drinking water projects, priority will be determined by the project priority system used for the drinking water state revolving fund set forth in 567—Chapter 44, Iowa Administrative Code. Priority will also be given to projects based on the date upon which construction could begin.

33.5(2) *Small community assistance fund priority.* Under the small community assistance fund, priority shall also be given to communities that have the greatest financial need. Factors used to determine need will include, but are not limited to: median household income as a percentage of the statewide median household income; residential user rates as a percentage of median household income; the existing and forecasted debt of the system; and the unemployment rate of the community.

33.5(3) *Large community assistance fund priority.* Under the large community assistance fund, priority will be given to communities that did not receive funds from the I-Jobs disaster recovery program, the community development block grant (CDBG) disaster allocation or the State Revolving Fund (SRF) federal American Recovery and Reinvestment Act (ARRA).

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 8510B**, IAB 2/10/10, effective 1/14/10; **ARC 8725B**, IAB 5/5/10, effective 6/9/10]

265—33.6(16,83GA,SF376) Project funding.

33.6(1) *Applications.* Applications will be accepted on forms developed by IFA and available at www.iowafinanceauthority.gov. IFA will coordinate with other applicable state or federal financing programs when possible. Applications for the large community assistance fund will be due October 30, 2009. Applications for the small community assistance fund will be due March 30, 2010.

33.6(2) *Costs.* All eligible costs must be documented to the satisfaction of the authority before proceeds may be disbursed.

33.6(3) *Record retention.* The recipient shall maintain records that document all costs associated with the project. Recipients shall agree to provide the authority access to these records. The recipient shall retain such records and documents for inspection and audit purposes for a period of three years from the date of the final grant payment.

33.6(4) *Site access.* The recipient shall agree to provide the authority, the department and the department's agent access to the project site at all times during the construction process to verify that the funds are being used for the purpose intended and that the construction work meets applicable state and federal requirements.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.7(16,83GA,SF376) Termination and rectification of disputes.

33.7(1) *Termination.* The authority shall have the right to terminate any grant when terms of the agreement have been violated. Grants are subject to termination if construction has not begun within one year of the execution of a grant agreement. The director will establish a repayment schedule for funds already disbursed to the recipient. All terminations will be in writing.

33.7(2) *Rectification of disputes.* Failure of the recipient to implement the approved project or to comply with the applicable requirements constitutes grounds for the authority to recapture or withhold funds. The recipient is responsible for ensuring that the identified problem(s) is rectified. Once the deficiency is corrected, the funds can be released. A recipient that disagrees with the director's withholding of funds may request a formal review of the action. The recipient must submit a request in writing to the director within 30 days of notification by the authority of its planned action.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and section 16.131 as amended by 2009 Iowa Acts, House File 281, and 2009 Iowa Acts, Senate File 376, section 13(4).

[Filed ARC 8080B (Notice ARC 7896B, IAB 7/1/09), IAB 8/26/09, effective 9/30/09]

[Filed Emergency ARC 8510B, IAB 2/10/10, effective 1/14/10]

[Filed ARC 8725B (Notice ARC 8511B, IAB 2/10/10), IAB 5/5/10, effective 6/9/10]

CHAPTER 37
RECOVERY ZONE BOND ALLOCATION

265—37.1(16) General. The American Recovery and Reinvestment Act of 2009 created two types of recovery zone ("RZ") bonds: recovery zone economic development ("RZED") bonds and recovery zone facility ("RZ facility") bonds. The applicable provisions are codified in Sections 1400U-1 – 1400U-3 of the Internal Revenue Code of 1986, as amended. The law provides that eligible issuers in Iowa may issue up to $90 million of RZED bonds and up to $135 million of RZ facility bonds. Through Notice 2009-50, the Internal Revenue Service published the applicable RZ bond allocations for Iowa, which amounts are included as Exhibit A to this chapter.

Pursuant to 2010 Iowa Acts, House File 2487 (the "Act"), the Iowa finance authority ("authority") has been charged with tracking the issuance of RZ bonds and making certain allocations of RZ bonding authority to ensure maximum use of this resource in the state.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.2(16) Forms. Information and forms necessary for compliance with provisions of the law are available upon request from the Iowa Finance Authority, 2015 Grand Avenue, Des Moines, Iowa 50312. The telephone number of the authority is (515)725-4900. Information and forms are also available at www.iowafinanceauthority.gov.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.3(16) Notice from the authority to issuers. The authority will provide written notice to each county and to each large municipality (defined as a city with a population exceeding 100,000) of the amount of RZ bonding authority that has been allocated to it by the Internal Revenue Service. This written notice will include information about waiving such authority, pursuant to rule 265—37.5(16), as well as notification of the requirement that issuers provide written notice to the authority of any issuance of RZ bonds.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.4(16) Notice from issuers to the authority. Within five business days of the issuance thereof (or within five business days of its receipt of the authority letter issued under rule 265—37.3(16), for those issuers that have issued RZ bonds prior to April 12, 2010), each county or large municipality that issues RZED bonds or RZ facility bonds (or that allocates RZ bond authority to a local issuer) shall give the authority written notice, on a form provided by the authority, detailing the amount and type of RZ bonds that were issued.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.5(16) Waiver of RZ bonding authority.

37.5(1) A county or large municipality that has received an allocation of RZ bonds may, prior to July 1, 2010, voluntarily waive all or part of such allocation to the authority by completing the applicable RZ bond waiver form provided by the authority.

37.5(2) As provided in the Act, any portion of a county or large municipality's RZ bond allocation that has not been used by July 1, 2010, is deemed waived, and such amount will be subject to reallocation by the authority pursuant to rule 265—37.7(16). The authority will consider an allocation (or a portion thereof) used if the issuer for such allocation has taken substantive action toward issuance of the applicable RZ bonds. "Substantive action" includes, but is not limited to, (a) the adoption of resolutions or ordinances authorizing the sale or issuance of bonds, or (b) the completion of procedures, such as public hearings, referenda or related petition periods, to vest authority for the issuance of bonds.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.6(16) Application for allocation of recaptured or waived RZ bond authority.

37.6(1) An applicant or beneficiary, or the duly authorized agent of an applicant or beneficiary, requesting an allocation must make an application by filing the form entitled "Application for Recovery

Zone Bonds" available from the authority. Such applicant must possess the ability to issue RZ bonds under state and federal law.

37.6(2) As part of its application, the applicant must include a copy of the resolution or other official action designating the recovery zone for which the application is being made.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.7(16) Allocations.

37.7(1) The authority will track the amount and type of RZ bonds issued and the amount of RZ bonding authority available to be allocated.

37.7(2) Allocations will only be made for eligible projects in those counties that received an allocation of authority to issue RZ bonds pursuant to IRS Notice 2009-50. While the allocations will be limited to projects within those counties that originally received an allocation, the amount of the allocation from the authority will not be limited to the original allocated amounts under Notice 2009-50.

37.7(3) Allocations shall be made to eligible applicants on the basis of the chronological order of receipt of applications. Chronological order of receipt shall be determined by the date, hour and minute indicated by the time stamp as affixed to the application at the offices of the authority.

37.7(4) All applications that are received by the authority on or prior to April 12, 2010, pursuant to the provisions of rule 265—37.6(16) shall be considered simultaneously received at the opening of business on April 12, 2010, and the same date, hour and minute shall be stamped on each application so received. If the total amount of allocations requested in all of the applications received on such date exceeds the total amount determined by the authority as available to be allocated, the applications will be considered for allocation in the order determined pursuant to the procedures set forth in subrule 37.7(5).

37.7(5) In order to determine the order of allocation to two or more applications that are simultaneously received pursuant to subrule 37.7(4) and for which there is insufficient capacity to allocate to each the full allotment requested, each such application shall be assigned a preference number determined by a random drawing to be conducted at the authority's offices within one week following the receipt of the applications. The authority shall notify the affected applicants in writing and shall post a notice at its offices of the time and place of the drawing not less than three days prior to the scheduled drawing. Any person desiring to attend and witness the drawing and assigning of preference numbers may do so. Each application shall be assigned an identification code that shall be written on the outside of the sealed envelope containing the application. The identification codes shall also be written on strips of paper and placed in individual envelopes and sealed. The sealed envelopes containing identification codes shall be placed in a container, mixed, and drawn from the container at random by a member of the authority's staff. The application corresponding with the identification code that is drawn first shall be placed first on the list of applicants to receive an allotment. The application corresponding with the identification code that is selected second shall be placed second on the list, and so forth. Drawings shall continue until all applications are assigned a place on the list of applications received.

37.7(6) Applications received after April 12, 2010, shall be added to the appropriate list (whether for RZED bonds or RZ facility bonds) depending upon the subject of the application in the chronological order received.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.8(16) Certification of allocation. Upon receipt of a completed application and verification that sufficient RZ bonding authority exists for such application, the authority shall promptly certify to the applicant the amount of the RZED bond or RZ facility bond allocation, as applicable, awarded to the project for which the application was submitted. The authority shall continue to award allocations for eligible projects until the available recovery zone bonding authority is allocated. If the remaining capacity is not sufficient to fully fund an application which is next in order for allocation, the authority shall notify the applicant of the amount that is available and the applicant shall have the option to take what is available within five calendar days of receiving notice of availability. If the applicant does not notify the authority of its decision to take the available allocation within five calendar days of receiving

notice of that option, an allotment shall be offered to the next application on the list under the same conditions.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.9(16) Expiration of allocations. An allocation of recovery zone bonding authority pursuant to this chapter shall remain valid for 120 days from the date of allocation. If the sale of bonds for which an allocation was made has not closed within such time, the allocation shall expire and the allotment shall revert to the authority to be reallocated, if possible; provided, however, that if the 120th day following the date of allocation is a Saturday, Sunday, or any day on which the offices of the state banking institutions or savings and loan associations in the state are authorized or required to close, the expiration date shall be extended to the first day thereafter which is not a Saturday, Sunday or previously described day.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.10(16) Resubmission of expired allocations. If an allocation expires, the applicant may resubmit its application for the same project or purpose. However, the resubmitted application shall be treated as a new application, and preference, priority or prejudice shall not be given to the application or the applicant as a result of the prior application.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

265—37.11(16) Application and allocation fees. The Iowa finance authority may set and charge reasonable fees for providing administrative assistance with regard to the filing of applications and the allocation of the recovery zone bond allotments in accordance with these rules.
[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

EXHIBIT A

	Recovery Zone Economic Development Bonds	**Recovery Zone Facility Bonds**
Iowa's Total Allocation	**$90,000,000**	**$135,000,000**
Large Municipalities		
Cedar Rapids	1,972,000	2,958,000
Des Moines	5,571,000	8,356,000
Counties		
Adair County	564,000	845,000
Adams County	0	0
Allamakee County	3,212,000	4,818,000
Appanoose County	0	0
Audubon County	382,000	574,000
Benton County	390,000	586,000
Black Hawk County	2,343,000	3,514,000
Boone County	0	0
Bremer County	447,000	670,000
Buchanan County	72,000	109,000
Buena Vista County	785,000	1,177,000
Butler County	411,000	616,000
Calhoun County	0	0
Carroll County	350,000	525,000
Cass County	0	0
Cedar County	0	0
Cerro Gordo County	0	0

	Recovery Zone Economic Development Bonds	Recovery Zone Facility Bonds
Iowa's Total Allocation	**$90,000,000**	**$135,000,000**
Cherokee County	1,795,000	2,693,000
Chickasaw County	0	0
Clarke County	648,000	972,000
Clay County	0	0
Clayton County	0	0
Clinton County	0	0
Crawford County	0	0
Dallas County	1,731,000	2,596,000
Davis County	612,000	918,000
Decatur County	865,000	1,298,000
Delaware County	463,000	694,000
Des Moines County	3,550,000	5,325,000
Dickinson County	0	0
Dubuque County	4,363,000	6,545,000
Emmet County	0	0
Fayette County	1,115,000	1,672,000
Floyd County	2,500,000	3,749,000
Franklin County	1,220,000	1,829,000
Fremont County	821,000	1,232,000
Greene County	0	0
Grundy County	221,000	332,000
Guthrie County	306,000	459,000
Hamilton County	1,578,000	2,367,000
Hancock County	853,000	1,280,000
Hardin County	0	0
Harrison County	0	0
Henry County	1,409,000	2,113,000
Howard County	1,654,000	2,481,000
Humboldt County	1,320,000	1,980,000
Ida County	0	0
Iowa County	0	0
Jackson County	32,000	48,000
Jasper County	692,000	1,038,000
Jefferson County	1,163,000	1,745,000
Johnson County	0	0
Jones County	286,000	429,000
Keokuk County	403,000	604,000
Kossuth County	604,000	906,000
Lee County	2,793,000	4,190,000
Linn County	1,280,000	1,920,000
Louisa County	837,000	1,256,000
Lucas County	0	0
Lyon County	370,000	555,000

	Recovery Zone Economic Development Bonds	Recovery Zone Facility Bonds
Iowa's Total Allocation	**$90,000,000**	**$135,000,000**
Madison County	435,000	652,000
Mahaska County	841,000	1,262,000
Marion County	857,000	1,286,000
Marshall County	2,431,000	3,647,000
Mills County	0	0
Mitchell County	962,000	1,443,000
Monona County	0	0
Monroe County	0	0
Montgomery County	588,000	882,000
Muscatine County	3,136,000	4,703,000
O'Brien County	149,000	223,000
Osceola County	0	0
Page County	2,274,000	3,411,000
Palo Alto County	547,000	821,000
Plymouth County	2,322,000	3,484,000
Pocahontas County	0	0
Polk County	6,992,000	10,487,000
Pottawattamie County	0	0
Poweshiek County	3,083,000	4,625,000
Ringgold County	246,000	368,000
Sac County	181,000	272,000
Scott County	0	0
Shelby County	0	0
Sioux County	946,000	1,419,000
Story County	0	0
Tama County	2,004,000	3,007,000
Taylor County	475,000	712,000
Union County	0	0
Van Buren County	125,000	187,000
Wapello County	910,000	1,365,000
Warren County	1,352,000	2,029,000
Washington County	0	0
Wayne County	0	0
Webster County	0	0
Winnebago County	1,304,000	1,956,000
Winneshiek County	4,090,000	6,134,000
Woodbury County	612,000	918,000
Worth County	0	0
Wright County	1,155,000	1,733,000

[**ARC 8709B**, IAB 5/5/10, effective 4/12/10]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2010 Iowa Acts, House File 2487.

[Filed Emergency ARC 8709B, IAB 5/5/10, effective 4/12/10]

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

[Prior to 7/1/83, Social Services[770] Ch 65]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The basis for the food assistance program is as provided in Title 7 of the Code of Federal Regulations. The purpose of this chapter is to provide for adoption of new and amended federal regulations as they are published, to establish a legal basis for Iowa's choice of administrative options when administrative options are given to the state in federal regulations, to implement the policy changes that the United States Department of Agriculture (USDA) directs states to implement that are required by law but are not yet included in federal regulations, and to implement USDA-approved demonstration projects and waivers of federal regulations.

DIVISION I

441—65.1(234) Definitions.

"Department" means the Iowa department of human services.

"Food assistance" means benefits provided by the federal program administered through Title 7, Chapter II of the Code of Federal Regulations, Parts 270 through 283.

"Notice of expiration" means either a message printed on an application for continued program participation, Review/Recertification Eligibility Document (RRED), Form 470-2881, which is automatically issued to the household, or a hand-issued Form 470-0325, Notice of Expiration.

"Parent" means natural, legal, or stepmother or stepfather.

"Sibling" means biological, legal, step- , half- , or adoptive brother or sister.

441—65.2(234) Application.

65.2(1) *Application filing.* Persons in need of food assistance benefits may file an application at any local department office in Iowa or over the Internet.

a. An application is filed the day a local department office receives an application for food assistance benefits that contains the applicant's name and address and is signed by either a responsible member of the household or the household's authorized representative. The application may be filed on:

(1) Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance;

(2) Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application; or

(3) Form 470-4080 or 470-4080(S), Electronic Food Assistance Application.

b. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open. An electronic application is considered received on the first department workday following the date the department office received the application.

c. A household shall complete a Health and Financial Support Application when any person in the household is applying for or receiving aid through the family investment program, family medical assistance program (FMAP)-related Medicaid, or the refugee resettlement assistance programs.

d. The application is complete when a completed application form is submitted.

e. Households receiving food assistance benefits in Iowa may apply for continued participation by submitting Form 470-2881, Review/Recertification Eligibility Document.

65.2(2) *Failure to provide verification.* When a household files an initial application and the department requests additional verification, the applicant shall have ten days to provide the requested verification. If the applicant fails to provide the verification within ten days, the department may deny the application immediately. If the applicant provides the department with the requested verification prior to the thirtieth day from the date of application, the department shall reopen the case and provide benefits from the date of application. If the household provides the verification in the second 30 days

after the date of the application, the department shall reopen the case and provide benefits from the date the verification was provided.

441—65.3(234) Administration of program. The food assistance program shall be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq., and in accordance with federal regulation, Title 7, Parts 270 through 283 as amended to June 19, 2006. A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the Division of Financial, Health, and Work Supports, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, (515)281-3133.

441—65.4(234) Issuance. The department shall issue food assistance benefits by electronic benefits transfer (EBT).

65.4(1) *Schedule.* Benefits for ongoing certifications shall be made available to households on a staggered basis during the first ten calendar days of each month.

65.4(2) *EBT cards.* EBT cards shall be mailed to clients.

a. Personal identification number selection. When a client receives the EBT card, the client shall call the automated response unit to select a personal identification number. The client must provide proof of identity before selecting the personal identification number.

b. Replacement of EBT cards. EBT cards shall be replaced within five business days after the client notifies the EBT customer service help desk of the need for replacement.

65.4(3) *Client training.* Written client training materials may either be mailed to clients or be handed to the clients if they visit the local office. Clients will be given in-person training upon request or if they are identified as having problems using the EBT system.

65.4(4) *Point-of-sale terminals.* Point-of-sale terminals allow clients to access food assistance benefits and retailers to redeem food sales.

a. Redemption threshold. The department will not place point-of-sale terminals with any authorized retailer with less than $100 in monthly food assistance redemptions. Those retailers may participate through a manual voucher process described in paragraph 65.4(5)*"b."*

b. Shipping. Government-supplied point-of-sale terminals may be shipped to authorized retailers along with instructions for installation of the equipment and training materials. A toll-free number is available for retailers needing assistance.

c. Replacement. The department shall ensure that government-supplied point-of-sale terminals that are not operating properly are repaired or replaced within 48 hours.

65.4(5) *Voucher processing.*

a. Emergency vouchers. Authorized retailers may use an emergency manual voucher if they cannot access the EBT host system.

(1) The client shall sign Form 470-2827, POS Voucher, to authorize a debit of the household's EBT account.

(2) The retailer shall clear the manual transaction as soon as the host system becomes operational.

(3) The retailer shall receive a payment of the actual amount of the voucher, up to a maximum of $50.

b. Manual vouchers. Authorized retailers without point-of-sale terminals and retailers whose equipment fails may use a manual voucher. If a manual voucher is used:

(1) The client shall sign Form 470-3980, Offline Food Stamp Voucher: Non Equipped Retailer (No POS), to authorize a debit of the household's EBT account.

(2) The retailer shall obtain a telephone authorization from the EBT retailer help desk before finalizing the purchase.

(3) The retailer shall clear the manual transaction within 30 days.

(4) If there are insufficient funds in the client's account when the voucher is presented, the client's account shall be debited for the amount in the account. The remainder of the amount owed shall be

deducted from benefits issued for subsequent months. If the next month's allotment is less than $50, the deduction shall not exceed $10.
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.5(234) Simplified reporting.

65.5(1) *Identification.* All households are subject to simplified reporting requirements.

65.5(2) *Determination of eligibility and benefits.* Eligibility and benefits for simplified reporting households shall be determined on the basis of the household's prospective income and circumstances.

65.5(3) *Certification periods.* Households shall be certified as follows:

a. Households that have no earned income and in which all adult members are elderly or disabled shall be assigned certification periods of 12 months.

b. All other households shall be assigned certification periods of six months.

c. Exceptions:

(1) A household that has unstable circumstances or that includes an able-bodied adult without dependents shall be assigned a shorter certification period consistent with the household's circumstances, but generally no less than three months.

(2) A shorter certification period may be assigned at application or recertification to match the food assistance recertification date to the family investment program or medical assistance annual review date.

65.5(4) *Reporting responsibilities.* Simplified reporting households are required to report changes as follows:

a. The household shall report if the household's total gross income exceeds 130 percent of the federal poverty level for the household size. The household must report this change within ten days of the end of the month in which the income exceeds this level. A categorically eligible household that reports income over 130 percent of the federal poverty level and that remains eligible for benefits shall not be required to make any additional report of changes.

b. A household containing an able-bodied adult without dependents shall report any change in work hours that brings that adult below 20 hours of work per week, averaged monthly. The household must report this change within ten days of the end of the month in which the change in work hours occurs.

65.5(5) *Verification submitted with report form.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(6) *Additional information and verification.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(7) *Action on reported changes.* The department shall act on all reported changes for households regardless of the household's reporting requirements.

65.5(8) *Entering or leaving simplified reporting.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(9) *Reinstatement.* Rescinded IAB 9/10/08, effective 10/1/08.

441—65.6(234) Delays in certification.

65.6(1) When by the thirtieth day after the date of application the agency cannot take any further action on the application due to the fault of the household, the agency shall give the household an additional 30 days to take the required action. The agency shall send the household a notice of pending status on the thirtieth day.

65.6(2) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is complete enough to determine eligibility, the application shall be processed. For subsequent months of certification, the agency may require a new application form to be completed when household circumstance indicates changes have occurred or will occur.

65.6(3) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is not complete enough to determine eligibility, the application shall be denied. The household shall be notified to file a new application and that it may be entitled to retroactive benefits.

441—65.7(234) Expedited service. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.8(234) Deductions.

65.8(1) *Standard allowance for households with heating or air-conditioning expenses.* When a household is receiving heating or air-conditioning service for which it is required to pay all or part of

the expense or receives assistance under the Low-Income Home Energy Assistance Act (LIHEAA) of 1981, the heating or air-conditioning standard shall be allowed.

a. The standard allowance for utilities which include heating or air-conditioning costs is $276 effective March 1, 2005.

b. This allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for fuels and other utilities for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

(4) Effective October 1, 2007, two dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction. Effective October 1, 2008, an additional two dollars, for a total of four dollars, will be subtracted from this amount to achieve continued cost neutrality.

65.8(2) *Heating expense.* Heating expense is the cost of fuel for the primary heating service normally used by the household.

65.8(3) *Telephone standard.* When a household is receiving a standard utility allowance under subrule 65.8(1) or 65.8(5) or is solely responsible for telephone expenses, a standard allowance shall be allowed.

a. This standard shall be $36 effective March 1, 2005.

b. This allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for telephone service for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

65.8(4) *Energy assistance payments.* For purposes of prorating the low income energy assistance payments to determine if households have incurred out-of-pocket expenses for utilities, the heating period shall consist of the months from October through March.

65.8(5) *Standard allowance for households without heating or air-conditioning expenses.* When a household is receiving some utility service other than heating or air-conditioning for which it is responsible to pay all or part of the expense, the nonheating or air-conditioning standard shall be allowed. These utility expenses cannot be solely for telephone.

a. This standard is $103 effective August 1, 1991.

b. Beginning October 1, 1992, this allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for electric service for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

(4) Effective October 1, 2007, two dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction. Effective October 1, 2008, an additional two dollars, for a total of four dollars, will be subtracted from this amount to achieve continued cost neutrality.

65.8(6) *Excluded payments.* A utility expense which is reimbursed or paid by an excluded payment, including HUD or FmHA utility reimbursements, shall not be deductible.

65.8(7) *Excess medical expense deduction.* Notwithstanding anything to the contrary in these rules or regulations, at certification, households having a member eligible for the excess medical expense deduction shall be allowed to provide verification of expenses so that a reasonable projection of the member's medical expenses anticipated to occur during the household's certification period can be made. The household may choose to claim actual expenses or to use the standard medical expense deduction.

a. Actual medical expense.

(1) The projection may be based on available information about the member's medical condition, public or private medical insurance coverage, and current verified medical expenses.

(2) Households that choose to claim actual medical expenses shall not be required to report changes in medical expenses that were anticipated to occur during the certification period.

b. Standard medical expense.

(1) A household may choose a standard medical expense deduction of $105 if the household incurs more than $35 per month in medical expenses.

(2) A household that chooses the standard deduction shall not be required to report changes in medical expenses during the certification period.

c. Rescinded IAB 8/1/07, effective 10/1/07.

65.8(8) *Child support payment deduction.* Rescinded IAB 5/2/01, effective 6/1/01.

65.8(9) *Standard deduction.* Each household will receive a standard deduction from income equal to 8.31 percent of the net income limit for food assistance eligibility. No household will receive an amount less than $144 or more than 8.31 percent of the net income limit for a household of six members. The amount of the standard deduction is adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.8(10) *Sharing utility standards.* Rescinded IAB 9/4/02, effective 10/1/02.

65.8(11) *Excess shelter cap.* Rescinded IAB 5/2/01, effective 6/1/01.

This rule is intended to implement Iowa Code section 234.12.

441—65.9(234) Treatment centers and group living arrangements. Alcohol or drug treatment or rehabilitation centers and group living arrangements shall complete Form 470-2724, Monthly Facility Report, on a monthly basis and return the form to the local department office where the center is assigned.

441—65.10(234) Reporting changes. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.11(234) Discrimination complaint. Individuals who feel that they have been subject to discrimination may file a written complaint with the Diversity Programs Unit, Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

441—65.12(234) Appeals. Fair hearings and appeals are provided according to the department's rules, 441—Chapter 7.

441—65.13(234) Joint processing.

65.13(1) *Joint processing with SSI.* The department will handle joint processing of supplemental security income and food assistance applications by having the social security administration complete and forward food assistance applications.

65.13(2) *Joint processing with public assistance.* The department shall jointly process public assistance and food assistance applications.

65.13(3) *Single interview for assistance.* In joint processing of public assistance and food assistance applications, the department shall conduct a single interview at initial application for both purposes.

441—65.14(234) Rescinded, effective 10/1/83.

441—65.15(234) Proration of benefits. Benefits shall be prorated using a 30-day month.

This rule is intended to implement Iowa Code section 234.12.

441—65.16(234) Complaint system. Clients wishing to file a formal written complaint concerning the food assistance program may submit Form 470-0323, or 470–0323(S), Food Assistance Complaint, to the office of field support. Department staff shall encourage clients to use the form.
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.17(234) Involvement in a strike. An individual is not involved in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The service area manager shall determine whether such a risk to the individual's physical or emotional well-being exists.

441—65.18(234) Rescinded, effective 8/1/86.

441—65.19(234) Monthly reporting/retrospective budgeting. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.20(234) Notice of expiration issuance.

65.20(1) Issuance of the automated Notice of Expiration will occur with the mailing of Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), or a hand-issued Form 470-0325, Notice of Expiration.

65.20(2) Issuance of the Notice of Expiration, Form 470-0325, will occur at the time of certification if the household is certified for one month, or for two months, and will not receive the automated Notice of Expiration.
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.21(234) Claims.

65.21(1) *Time period.* Inadvertent household error claims shall be calculated back to the month the error originally occurred to a maximum of three years before the month of discovery of the overissuance. Agency error claims shall be calculated back to the month the error originally occurred to a maximum of one year before the month of discovery of the overissuance.

65.21(2) *Suspension status.* Rescinded IAB 7/1/98, effective 8/5/98.

65.21(3) *Application of restoration of lost benefits.* Rescinded IAB 3/6/02, effective 5/1/02.

65.21(4) *Demand letters.* Households that have food assistance claims shall return the repayment agreement no later than 20 days after the date the demand letter is mailed.

a. For agency error and inadvertent household error, when households do not return the repayment agreement by the due date or do not timely request an appeal, allotment reduction shall occur with the first allotment issued after the expiration of the Notice of Adverse Action time period.

b. For intentional program violation, when households do not return the repayment agreement by the due date, allotment reduction shall occur with the next month's allotment.

65.21(5) *Adjustments for claim repayment.* A household or authorized representative may initiate a claim repayment by using benefits in an EBT account. The client or authorized representative shall complete Form 470-2574, EBT Adjustment Request, to authorize adjustments to a household's EBT account.

65.21(6) *Collection of claims.* Rescinded IAB 5/30/01, effective 8/1/01.
[**ARC 7928B**, IAB 7/1/09, effective 9/1/09]

441—65.22(234) Verification.

65.22(1) *Required verification.*

a. Income. Households shall be required to verify income at time of application, recertification and when income is reported or when income changes with the following exceptions:

1. Households are not required to verify the public assistance grant.

2. Households are not required to verify job insurance benefits when the information is available to the department from the department of employment services.

3. Households are only required to verify interest income at the time of application and recertification.

b. Dependent care costs. Rescinded IAB 3/10/10, effective 2/10/10.

c. Medical expenses. Households shall be required to verify medical expenses at the time of application and whenever a change is reported. For recertification:

(1) A household that chose to claim actual expenses must verify medical expenses.

(2) A household that chose the standard medical expense deduction shall be required to declare only if the excess expense still exists.

d. Shelter costs. Rescinded IAB 3/10/10, effective 2/10/10.

e. Utilities. Rescinded IAB 3/10/10, effective 2/10/10.

f. Telephone expense. Rescinded IAB 5/2/01, effective 6/1/01.

g. Child support payment deduction. Households shall be required to verify legally obligated child support and child medical support payments made to a person outside of the food assistance household only at certification and recertification and whenever the household reports a change.

65.22(2) *Failure to verify.* When the household does not verify an expense as required, no deduction for that expense will be allowed.

65.22(3) *Special verification procedures.* Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a second face-to-face interview and additional documentation requirements in accordance with department of inspections and appeals' rules 481—Chapter 72.

Clients are required to cooperate with the investigation division of the department of inspections and appeals in establishing eligibility factors, including attending requested interviews. Refusal to cooperate will result in denial or cancellation of the household's food assistance benefits. Once denied or terminated for refusal to cooperate, the household may reapply but shall not be determined eligible until cooperation occurs.

[**ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—65.23(234) Prospective budgeting.

65.23(1) *Weekly or biweekly income.* The department shall convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program procedures.

65.23(2) *Income averaging.* The department shall average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

441—65.24(234) Inclusion of foster children in household. Foster children living with foster parents will not be considered to be members of the food assistance household unless the household elects to include the foster children in the household. Foster care payments received for foster children not included in the household will be excluded from the income of the household receiving the payment.

441—65.25(234) Effective date of change. A food assistance change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

441—65.26(234) Eligible students. A student who is enrolled in an institution of higher education shall meet student eligibility criteria if the student:

1. Is employed for an average of 20 hours per week and is paid for this employment; or

2. Is self-employed for an average of 20 hours per week and receives average weekly earnings at least equal to the federal minimum wage multiplied by 20 hours.

441—65.27(234) Voluntary quit or reduction in hours of work.

65.27(1) *Applicant households.* A member of an applicant household who without good cause voluntarily quits a job or reduces hours of work to less than 30 hours weekly within 30 days before the date the household applies for benefits shall be disqualified from participating in the food assistance program according to the provisions of paragraphs 65.28(12)*"a"* and *"b."*

65.27(2) *Participating individuals.* Participating individuals are subject to the same disqualification periods as provided under subrule 65.28(12) when the participating individuals voluntarily quit employment without good cause or voluntarily reduce hours of work to less than 30 hours per week, beginning with the month following the adverse notice period.

441—65.28(234) Work requirements.

65.28(1) *Persons required to register.* Each household member who is not exempt by subrule 65.28(2) shall be registered for employment at the time of application, and once every 12 months after initial registration, as a condition of eligibility. Registration is accomplished when the applicant signs an application form that contains a statement that all members in the household who are required to register for work are willing to register for work. This signature registers all members of that food assistance household that are required to register.

65.28(2) *Exemptions from work registration.* The following persons are exempt from the work registration requirement:

a. A person younger than 16 years of age or a person 60 years of age or older. A person aged 16 or 17 who is not a head of a household or who is attending school, or is enrolled in an employment training program on at least a half-time basis is exempt.

b. A person physically or mentally unfit for employment.

c. A household member subject to and complying with any work requirement under Title IV of the Social Security Act including mandatory PROMISE JOBS referral.

d. A parent or other household member who is responsible for the care of a dependent child under age six or an incapacitated person.

e. A person receiving unemployment compensation.

f. A regular participant in a drug addiction or alcohol treatment and rehabilitation program which is certified by the Iowa department of public health, division of substance abuse.

g. A person who is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

h. A student enrolled at least half-time in any recognized school, recognized training program, or an institution of higher education (provided that students have met the requirements of federal regulation, Title 7, Part 273.5, as amended to December 31, 1986).

65.28(3) *Losing exempt status.* Persons who lose exempt status due to any change in circumstances that is subject to the reporting requirements shall register for employment when the change is reported. Persons who lose exempt status due to a change in circumstances that is not subject to the reporting requirements for that household shall register for employment no later than at the household's next recertification.

65.28(4) *Registration process.* Upon reaching a determination that an applicant or a member of the applicant's household is required to register, the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failure to comply shall be explained to the applicant. A written statement of the above shall be provided to each registrant in the household. The written statement shall also be provided at recertification and when a previously exempt member or a new household member becomes subject to work registration.

Registration for all nonexempt household members required to work register is accomplished when the applicant or recipient signs an application, recertification, or reporting form containing an affirmative response to the question, "Do all members who are required to work register and participate in job search agree to do so?" or similarly worded statement.

65.28(5) *Deregistration.* Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.28(6) *Work registrant requirements.* Work registrants shall respond to a request from the department or its designee for supplemental information regarding employment status or availability for work.

65.28(7) *Employment and training program.*

a. The employment and training program for food assistance recipients is designed to assist:

(1) Persons who have lost jobs or are underemployed and who need new skills in order to reenter the workplace because there are no jobs available for which the persons are trained.

(2) Persons who have been out of the workforce for a period of time to regain licensure or certification in an area in which they are already trained.

(3) Persons who wish to upgrade their employment for better wages and benefits.

b. The department or its designee shall serve as the provider of employment and training services for food assistance recipients who wish to volunteer, except for those who are also recipients of family investment program (FIP) benefits. Federal law prohibits FIP recipients from participating in any food assistance employment and training program.

c. The program offers a range of services from basic skills to advanced training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a volunteer to engage in vocational testing activities when deemed necessary to determine if a component is appropriate for improving the volunteer's opportunity for employment.

65.28(8) *Employment and training components.* Employment and training components include individual job search, job club, educational services, and job retention services. The department or its designee shall offer employment and training components subject to the availability of sufficient funding to cover program costs. Availability of components may vary among the areas where employment and training are offered.

a. Individual job search. The individual job search shall be modeled after the family investment program's PROMISE JOBS individual job search component, as described at 441—subrule 93.6(2).

b. Job club. The employment and training job club shall be modeled after the family investment program's PROMISE JOBS job club, as described at 441—subrule 93.6(1).

c. Educational services. Educational services offered shall include general educational development (GED), adult basic education (ABE), English as a second language (ESL), and vocational training or educational opportunities limited to a two-year college degree. Educational services may include, but are not limited to, obtaining continuing education credit hours needed for a recipient to become recertified or to renew licensure for a profession.

d. Job retention services. Job retention services are intended to provide needed assistance with costs associated with beginning employment. Services are available only to persons who have received employment or training services under this subrule. Job retention services will be offered up to 90 days after the person secures employment. Services may include payment of:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) The cost of testing, certification, licensing, bonding, or legal services required for employment.

(3) The cost of equipment, tools, uniforms, or other special clothing required by the job.

(4) Other reasonable and necessary costs related to starting and retaining employment.

65.28(9) *Exemptions from employment and training programs.* Rescinded IAB 5/5/10, effective 4/15/10.

65.28(10) *Time spent in an employment and training program.* Rescinded IAB 5/5/10, effective 4/15/10.

65.28(11) *Supportive services.* Program participants shall be provided with services necessary to complete an employment and training component to the extent allowable under federal regulations at 7 CFR 237.7(e)(4) as amended to January 1, 2009, and to the extent there is sufficient funding to cover the costs.

a. The department shall provide participants in employment and training components an allowance for costs of transportation or other costs reasonably necessary and directly related to participation in the components as follows:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) Reasonable and necessary costs of attending a specific course of study, such as tuition, books, fees, training manuals, tools, equipment, uniforms and special clothing, safety items, and other items that all students in the course are required to have.

b. The department may authorize the employment and training service provider to reimburse the provider of care directly for the costs of dependent care expenses that the employment and training service provider determines to be necessary for the participation of a person in the components.

(1) Reimbursement for dependent care shall be authorized only to the extent that another source is not available to provide the care at no cost to the employment and training program and shall be based on the child care assistance program reimbursement rates as described at 441—paragraph 170.4(7)*"a."*

(2) The caretaker relative of a dependent in a family receiving FIP is not eligible for the dependent care reimbursement.

65.28(12) *Failure to comply.* This subrule applies only to persons who are mandatory work registrants as required by subrule 65.28(1).

a. When a person has refused or failed without good cause to comply with the work registration requirements in this rule, that person shall be ineligible to participate in the food assistance program as follows:

(1) First violation: The later of (1) the date the individual complies with the requirement; or (2) two months.

(2) Second violation: The later of (1) the date the individual complies with the requirement; or (2) three months.

(3) Third and subsequent violations: The later of (1) the date the individual complies with the requirement; or (2) six months.

b. The disqualification period shall begin with the first month following the expiration of the adverse notice period, unless a fair hearing is requested.

65.28(13) *Noncompliance with comparable requirements.* The department shall treat a mandatory work registrant's failure to comply with an unemployment compensation requirement that is comparable to a food assistance work registration requirement as a failure to comply with the corresponding food assistance requirement. Disqualification procedures in subrule 65.28(12) shall be followed.

65.28(14) *Ending disqualification.* Following the end of the disqualification periods for noncompliance and as provided in rules 441—65.27(234) and 441—65.28(234), participation may resume.

a. An applicant disqualified under subrule 65.27(1) may be approved for benefits after serving the minimum disqualification period and complying with the work requirement, as follows:

(1) If the applicant voluntarily quit a job, the applicant must obtain a job comparable to the one that the applicant quit.

(2) If the applicant voluntarily reduced hours of employment to less than 30 hours per week, the applicant must start working 30 or more hours per week.

b. A disqualified individual who is a member of a currently participating eligible household shall be added to the household after the minimum disqualification period has been served and the person has complied with the failed requirement as follows:

(1) If the member failed or refused to register for work with the department, the member complies by registering.

(2) If the member voluntarily quit a job, the member must obtain a job comparable to the one quit.

(3) If the member voluntarily reduced hours of employment to less than 30 hours per week, the member must start working 30 or more hours per week.

c. An individual may reestablish eligibility during a disqualification period by becoming exempt from the work requirement as provided in subrule 65.28(2).

65.28(15) *Suitable employment.* Employment shall be considered unsuitable if:

a. The wage offered is less than the highest of the applicable federal minimum wage, the applicable state minimum wage, or 80 percent of the federal minimum wage if neither the federal nor state minimum wage is applicable.

b. The employment offered is on a piece-rate basis and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wages specified in paragraph *"a"* above.

c. The household member, as a condition of employment or continuing employment, is required to join, resign from, or refrain from joining a legitimate labor organization.

d. The work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A) (commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).

e. The household member involved can demonstrate or the department otherwise becomes aware that:

(1) The degree of risk to health and safety is unreasonable.

(2) The member is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

(3) The employment offered within the first 30 days of registration is not in the member's major field of experience.

(4) The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two hours per day, not including the transporting of a child to and from a child care facility. Employment shall also not be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.

(5) The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.

65.28(16) *Applicants for supplemental security income (SSI) and food assistance.* Household members who are jointly applying for SSI and for food assistance shall have the requirements for work registration waived until:

a. They are determined eligible for SSI and thereby become exempt from work registration, or

b. They are determined ineligible for SSI whereupon a determination of work registration status will be made.

65.28(17) *Determining good cause.* The department or its designee shall determine whether good cause exists for failure to comply with the work registration, employment and training, and voluntary quit requirements in 441—Chapter 65. In determining whether good cause exists, the facts and circumstances shall be considered, including information submitted by the household member involved and the employer.

Good cause shall include circumstances beyond the member's control, such as, but not limited to, illness of the registrant or of another household member requiring the presence of the registrant, a household emergency, the unavailability of transportation, or the lack of adequate child care for children who have reached age 6 but are under age 12.

65.28(18) *Measuring the three-year period for able-bodied nonexempt adults without dependents.* The three-year period as provided for in federal regulations at 7 CFR 273.24 as amended to June 19, 2002, starts on December 1, 2002, and ends November 30, 2005. Subsequent three-year periods start with the month of December following the end of the previous period.

65.28(19) *Mini-simplified food assistance program.*

a. Scope. The department operates a mini-simplified food assistance program for households that:

(1) Also receive benefits under the family investment program; and

(2) Include a parent who is exempt from food assistance requirements for work registration due to caring for a child under the age of six.

b. Effect. The mini-simplified food assistance program allows replacement of certain food assistance program work rules with work rules of the Temporary Assistance to Needy Families program. The value of the household's monthly food assistance benefits shall be combined with the household's monthly family investment program benefit amount to determine the maximum number of hours the department can require a household member under the family investment program to participate in an unpaid work activity that is subject to the federal Fair Labor Standards Act. Maximum required hours of participation for a month are determined by dividing the total amount of benefits by the state or federal minimum wage, whichever wage is higher.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8712B**, IAB 5/5/10, effective 4/15/10]

441—65.29(234) Income.

65.29(1) *Uneven proration of self-employment income.* Once a household with self-employment income is determined eligible based on its monthly net self-employment income, the household has the following options for computation of the benefit level:

a. Using the same net monthly self-employment income which was used to determine eligibility, or

b. Unevenly prorating the household's annual self-employment income over the period for which the household's self-employment income was averaged to more closely approximate the time when the income is actually received. If this option is chosen, the self-employment income assigned in any month together with other income and deductions at the time of certification cannot result in the household's exceeding the maximum monthly net income eligibility standards for the household's size.

65.29(2) *Job insurance benefits.* When the department of human services uses information provided by the department of workforce development to verify job insurance benefits, the benefits shall be considered received the second day after the date that the check was mailed. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

When the client notifies the agency that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A benefit adjustment shall be made when indicated. The client must report the discrepancy before the benefit month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the benefit month, whichever is later, in order to receive corrected benefits.

65.29(3) *Exclusion of income from 2000 census employment.* Rescinded IAB 9/4/02, effective 10/1/02.

65.29(4) *Interest income.* Prorate interest income by dividing the amount anticipated during the certification period by the number of months in the certification period.

65.29(5) *Social security plans for achieving self-support (PASS).* Notwithstanding anything to the contrary in these rules or regulations, exclude income amounts necessary for fulfillment of a plan for achieving self-support (PASS) under Title XVI of the Social Security Act.

65.29(6) *Student income.* In determining eligibility, the department shall exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

a. Notwithstanding anything to the contrary in these rules or regulations, the department shall exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation and miscellaneous personal expenses (other than living expenses).

b. If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students shall receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

c. For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.29(7) *Elementary and high school student income.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(8) *Vendor payments.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(9) *HUD or FmHA utility reimbursement.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(10) *Welfare reform and regular household honorarium income.* All moneys paid to a food assistance household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

65.29(11) *Income of ineligible aliens.* The department shall use all but a pro-rata share of ineligible aliens' income and deductible expenses to determine eligibility and benefits of any remaining household members.

65.29(12) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to the household.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.30(234) Resources.

65.30(1) *Jointly held resources.* When property is jointly held it shall be assumed that each person owns an equal share unless the intent of the persons holding the property can be otherwise established.

65.30(2) *Resource limit.* The resource limit for a household that includes a person aged 60 or over or a disabled person is $3000. The resource limit for other households is $2000. These amounts are adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.30(3) *Resources of SSI and FIP household members.* Notwithstanding anything to the contrary in these rules or in federal regulations, all resources of SSI or FIP recipients are excluded. For food assistance purposes, those members' resources, if identified, cannot be included when a household's total resources are calculated.

65.30(4) *Earned income tax credits.* Notwithstanding anything to the contrary in these rules or in federal regulations, earned income tax credits (EITC) shall be excluded from consideration as a resource for 12 months from the date of receipt if:

a. The person receiving the EITC was participating in the food assistance program at the time the credits were received; and

b. The person participated in the program continuously during the 12-month period.

65.30(5) *Student income.* Exclude from resources any income excluded by subrule 65.29(6).

65.30(6) *Motor vehicles.* One motor vehicle per household shall be excluded without regard to its value. The value of remaining motor vehicles shall be determined using federal regulations at 7 CFR 273.8, as amended to April 29, 2003.

65.30(7) *Retirement accounts.* Exclude from resources the value of:

a. Any funds in a plan, contract, or account described in Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c)(18) of the Internal Revenue Code of 1986.

b. Any funds in a Federal Thrift Savings Plan account as provided in Section 8439 of Title 5, United States Code.

c. Any retirement program or account included in any successor or similar provision that may be enacted and determined to be exempt from tax under the Internal Revenue Code of 1986.

d. Any other retirement plans, contracts, or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

65.30(8) *Education accounts.* Exclude from resources the value of:

a. Any funds in a qualified tuition program described in Section 529 of the Internal Revenue Code of 1986 or in a Coverdell Education Savings Account under Section 530 of the Internal Revenue Code.

b. Any other education plans, contracts or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

441—65.31(234) Homeless meal providers. When a local office of the department is notified that an establishment or shelter has applied to be able to accept food assistance benefits for homeless persons, staff shall obtain a written statement from the establishment or shelter. The statement must contain information on how often meals are served by the establishment or shelter, the approximate number of meals served per month, and a statement that the establishment or shelter does serve meals to homeless persons. This information must be dated and signed by a person in charge of the administration of the establishment or shelter and give the person's title or function with the establishment.

The establishment or shelter shall cooperate with agency staff in the determination of whether or not meals are served to the homeless.

441—65.32(234) Basis for allotment. The minimum benefit amount for all eligible one-member and two-member households shall be 8 percent of the maximum monthly allotment for a household size of one member.

441—65.33(234) Dependent care deduction. Households shall be allowed a deduction for the amount of monthly dependent care expenses.
[**ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—65.34(234) Exclusion of advance earned income tax credit payments from income. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.35(234) Migrant and seasonal farm worker households. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.36(234) Electronic benefit transfer (EBT) of food stamp benefits. Rescinded IAB 3/5/03, effective 5/1/03.

441—65.37(234) Eligibility of noncitizens. The following groups of aliens who are lawfully residing in the United States and are otherwise eligible are eligible for food assistance benefits:

65.37(1) Aliens who are receiving benefits or assistance for blindness or disability as specified in 7 CFR 271.2, as amended to April 6, 1994, regardless of their immigration date.

65.37(2) Aliens who have been residing in the United States for at least five years as legal permanent residents.

65.37(3) Aliens who hold one of the following statuses:

a. A refugee admitted under Section 207 of the Immigration and Nationality Act.

b. A Cuban or Haitian entrant admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.

c. An Amerasian immigrant admitted under Section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act.

d. An asylee admitted under Section 208 of the Immigration and Nationality Act.

e. An alien whose deportation or removal has been withheld under Section 243(h) or 2411(b)(3) of the Immigration and Nationality Act.

65.37(4) Aliens aged 18 or under, regardless of their immigration date. The department shall exclude the income and resources of a sponsor when determining food assistance eligibility and benefits for an alien aged 18 or under.

441—65.38(234) Income deductions. Notwithstanding anything to the contrary in these rules or regulations, student households cannot receive an income deduction for dependent care expenses that were excluded from educational income.

441—65.39(234) Categorical eligibility. Notwithstanding anything to the contrary in these rules or in federal regulations, recipients of state or local general assistance (GA) programs are subject to categorical eligibility provisions of the food assistance program provided that the state or local program:

1. Has income limits at least as stringent as the food assistance gross income test; and
2. Gives assistance other than one-time emergency payments that cannot be given for more than one continuous month.

441—65.40(234) Head of the household. Rescinded IAB 8/11/99, effective 11/1/99.

441—65.41(234) Actions on changes increasing benefits. Action on changes resulting in an increase in benefits will take place after the verification is received.

441—65.42(234) Work transition period. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.43(234) Household composition. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.44(234) Reinstatement.

65.44(1) The department shall reinstate assistance without a new application when the element that caused termination of a case no longer exists and eligibility can be reestablished prior to the effective date of cancellation.

65.44(2) When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date all information required to establish eligibility is provided.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—65.45(234) Conversion to the X-PERT system. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.46(234) Disqualifications. Notwithstanding anything to the contrary in these rules, food assistance program violation disqualifications for persons who are not participating in the food assistance program shall be imposed in the same manner as program violation disqualifications are imposed for persons who are participating in the food assistance program.

65.46(1) *First and second violations.* Notwithstanding anything to the contrary in these rules or regulations, the disqualification penalty for a first intentional program violation shall be one year except for those first violations involving a controlled substance. The disqualification penalty for a second intentional violation and any first violation involving a controlled substance shall be two years.

65.46(2) *Conviction on trafficking in food assistance benefits.* The penalty for any individual convicted of trafficking in food assistance benefits of $500 or more shall be permanent disqualification.

65.46(3) *Receiving or attempting to receive multiple benefits.* An individual found to have made a fraudulent statement or representation with respect to identity or residency in order to receive multiple benefits shall be ineligible to participate in the food assistance program for a period of ten years.

65.46(4) *Fleeing felons and probation or parole violators.* Rescinded IAB 10/3/01, effective 10/1/01.

65.46(5) *Conviction of trading firearms, ammunition or explosives for benefits.* The penalty for any individual convicted of trading firearms, ammunition or explosives for food assistance benefits shall be permanent disqualification.

441—65.47(234) Eligibility of noncitizens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.48(234) Sponsored aliens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.49(234) Providing information to law enforcement officials. Rescinded IAB 10/3/01, effective 10/1/01.

441—65.50(234) No increase in benefits. When a household's means-tested federal, state, or local public assistance cash benefits are reduced because of a failure to perform an action required by the public assistance program, the department shall reduce the household's food assistance benefit allotment by 10 percent as provided for in federal regulations at 7 CFR 273.11(j), (k), and (l) as amended to June 1, 2001, for the duration of the other program's penalty.

441—65.51(234) State income and eligibility verification system. The department shall maintain and use an income and eligibility verification system (IEVS) as specified in 7 CFR 272.8 as amended to November 21, 2000.

441—65.52(234) Systematic alien verification for entitlements (SAVE) program. The department shall participate in the SAVE program established by the U.S. Bureau of Citizenship and Immigration Service (BCIS) as specified in 7 CFR 272.11 as amended to November 21, 2000, in order to verify the validity of documents provided by aliens applying for food assistance benefits with the central data files maintained by BCIS.

These rules are intended to implement Iowa Code section 234.12.

441—65.53 to **65.100** Reserved.

DIVISION II
[Prior to 10/13/93, 441—65.1(234) to 65.41(234)]
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1 Amendments to subrules 65.30(5) and 65.130(7) and rules 65.32(234) and 65.132(234) effective 10/1/96.

2 Subrules 65.8(11) and 65.108(11) effective 1/1/97.

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

a. Persons denied RCA because the amount of payment would be less than $10.

b. Rescinded IAB 7/30/08, effective 10/1/08.

c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

a. Subject to paragraphs *"b"* and *"c"* below, Medicaid shall be available to persons who:

(1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).

(2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A "period of 30 days" is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain "under the jurisdiction of the institution" a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of "essential person" in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249. Medical assistance shall also be available to the individual's dependent relative as defined in 441—subrule 51.4(4).

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and

b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and

c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed $2,000 for applicant households or $5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.

b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).

c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2)*"a," "b," "c,"* and *"d"* shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1)*"a"* but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8)*"c"* and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the $30 or the $30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with paragraphs 75.57(9)*"b"* and *"c."*

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed $10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, "family" shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. "Family" also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months' Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph *"f"* below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs *"g"* and *"i"* of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional six-month period as required in paragraph 75.1(31)*"h,"* unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The family offers a good cause beyond the family's control.

4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client's achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family's average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1)*"a,"* including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph *"g"* or *"i"* above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person's monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person's resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person's income and resources shall be determined as under the SSI program.

75.1(34) *Specified low-income Medicare beneficiaries.* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) *Medically needy persons.*

a. Coverage groups. Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. Resources and income of all persons considered.

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. Resources.

(1) The resource limit for adults in SSI-related households shall be $10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9)*"b," "c," "g," "h,"* and *"i"* regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months' net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158

Each additional person $116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35)*"b"* shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months' MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that

period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.

2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.

3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3" above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) *Expanded specified low-income Medicare beneficiaries.* As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person is not otherwise eligible for Medicaid.

b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.* Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) *Continued Medicaid for disabled children from August 22, 1996.* Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) *Working persons with disabilities.*

a. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.

(4) They receive earned income from employment or self-employment or are eligible under paragraph *"c."*

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.

(6) They have paid any premium assessed under paragraph *"b"* below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established for a 12-month period based on projected average monthly income for the 12-month period. The monthly premium established shall not be increased for any reason during the 12-month period. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively during the 12-month period if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$33
180% of Federal Poverty Level	$53
220% of Federal Poverty Level	$73
250% of Federal Poverty Level	$94
280% of Federal Poverty Level	$109
310% of Federal Poverty Level	$129
340% of Federal Poverty Level	$154
370% of Federal Poverty Level	$188
400% of Federal Poverty Level	$221
430% of Federal Poverty Level	$255
460% of Federal Poverty Level	$295
510% of Federal Poverty Level	$342
590% of Federal Poverty Level	$396
680% of Federal Poverty Level	$457
775% of Federal Poverty Level	$524
900% of Federal Poverty Level	$608

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the premium must be paid in full within the calendar month following the month the payment was due for reopening.

(8) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3694, Billing Statement, shall be used for billing and collection.

c. Persons receiving assistance under this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph *"a"* continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *"a"* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and
2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or
- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Women eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available to women as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group:

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who are of childbearing age, are capable of bearing children but are not pregnant, and have income that does not exceed 200 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

b. Application.

(1) Women eligible under subparagraph 75.1(41)*"a"*(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) Women requesting assistance based on subparagraph 75.1(41)*"a"*(2) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of a woman applying under subparagraph 75.1(41)*"a"*(2) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 441—subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in 441—subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in 441—paragraph 75.54(1)*"b."*

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.
2. Child support.
3. Alimony.
4. Social security and railroad retirement benefits.
5. Worker's compensation and disability payments.
6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in 441—subrule 75.57(2).

(5) Disregard of changes. A woman found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) *Medicaid for independent young adults.* Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

a. The person is at least 18 years of age and under 21 years of age.

b. On the person's eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) *Medicaid for children with disabilities.* Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) *Presumptive eligibility for children.* Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. Qualified entity. A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

b. Application process. Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1)*"f."* The qualified entity shall use the department's Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child's presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. Eligibility requirements. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household's gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child's eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7833B**, IAB 6/3/09, effective 8/1/09; **ARC 7929B**, IAB 7/1/09, effective 7/1/09; **ARC 7931B**, IAB 7/1/09, effective 7/1/09; **ARC 8095B**, IAB 9/9/09, effective 10/14/09; **ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8261B**, IAB 11/4/09, effective 10/15/09; **ARC 8439B**, IAB 1/13/10, effective 3/1/10; **ARC 8503B**, IAB 2/10/10, effective 1/13/10; **ARC 8713B**, IAB 5/5/10, effective 8/1/10]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

75.2(5) When the department receives information through a cross-match with Iowa workforce development department and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Obligor Insurance Questionnaire, to the absent parent in order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

[**ARC 7546B**, IAB 2/11/09, effective 4/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, to all monetary claims which the member may have against third parties.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be

construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2)*"d"* shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater

than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the

seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. Definition. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35and chapter 514H.

[**ARC 8443B**, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person

refuses to obtain a social security number because of well-established religious objections. The term "well-established religious objections" means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

"Incapable of expressing intent" shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

"Institution" shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) *Determining residency.* Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person's state of residence is:

1. That of the parent applying for Medicaid on the person's behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
2. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
4. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person's parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is in institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.

2. Short-term, non-cash, in-kind emergency disaster relief.

3. Assistance or benefits under the National School Lunch Act.

4. Assistance or benefits under the Child Nutrition Act of 1966.

5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;

2. Granted asylum under Section 208 of the Immigration and Nationality Act;

3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;

4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;

5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or

6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

(3) An alien child under the age of 19 who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

(4) A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act.

(5) An alien who has been granted asylum under Section 208 of the Immigration and Nationality Act.

(6) An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0466 (Spanish);
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS);

c. Except as provided in paragraph *"f,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d"* or *"e."* An applicant or member shall have a reasonable period to obtain and provide proof of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request to obtain and provide proof is issued to an applicant or member and continues to the date when the proof is provided or the date when the department establishes that the applicant or member is no longer making a good-faith effort to obtain the proof, whichever is earlier.

(2) Medicaid eligibility shall continue for members during the reasonable period. Medicaid shall not be approved for applicants until acceptable documentary evidence is provided.

(3) A reference to a form in paragraph *"d"* or *"e"* includes any successor form.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or
2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of

identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is eligible for child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is eligible for adoption or foster care assistance funded under Part E of Title IV of the federal Social Security Act; or

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

g. If no other identity documentation allowed by subparagraph 75.11(2)*"e"*(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)*"e"*(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

75.11(3) *Deeming of sponsor's income and resources.*

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and, in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor's income and resources no longer applies.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7932B**, IAB 7/1/09, effective 7/1/09; **ARC 8096B**, IAB 9/9/09, effective 10/14/09; **ARC 8642B**, IAB 4/7/10, effective 6/1/10]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase "inmate of a public institution" is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

This rule is intended to implement Iowa Code section 249A.3.

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for each applicant or member as well as for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when good cause as defined in subrule 75.14(8) for refusal to cooperate is established.

a. The applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the applicant or member:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The income maintenance unit shall make the determination of whether or not the applicant or member has cooperated.

75.14(2) Failure of the applicant or member to cooperate shall result in denial or cancellation of the person's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing

paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Referrals to the child support recovery unit for Medicaid applicants or members. The department shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

a. A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. *"Prompt notice"* means within two working days of the date assistance is approved.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) and 75.14(5) which require the applicant or member to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the

income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or member that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not

child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds $500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility.

Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. Clients receiving a VA pension. The amount of $90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall

include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[**ARC 8444B**, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) *Multiple pregnancy.* If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) *Cost of examination.* When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under

the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form

470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Redeterminations of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2)*"b."*

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

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

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

(1) There was a serious illness or death of the parent or a member of the parent's family.

(2) There was a family emergency or household disaster, such as a fire, flood, or tornado.

(3) The parent offers a good cause beyond the parent's control.

(4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.*

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall be completed whenever:

(1) A premium rate, deductible, or coinsurance changes,

(2) A person covered under the policy loses full Medicaid eligibility,

(3) Changes in employment or hours of employment affect the availability of health insurance,

(4) The insurance carrier changes,

(5) The policyholder leaves the Medicaid home, or

(6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16)*"a,"* shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09; **ARC 8503B**, IAB 2/10/10, effective 1/13/10]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2009, through June 30, 2010, this average statewide cost shall be $4,598.61 per month or $151.27 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period

shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)*"c"*);
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)*"d"*); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.*

a. The entire amount used to purchase an annuity on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in subparagraphs (1) through (3) of this paragraph and also meets the condition described in subparagraph (4).

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;
2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and
3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(4) Iowa is named as the remainder beneficiary either:

1. In the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

2. In the second position after the community spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

b. Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in 75.23(9)*"a"* were met.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09; **ARC 8444B**, IAB 1/13/10, effective 3/1/10]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in

place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual.

For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2009, to June 30, 2010, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $4,189 per month.

(2) and (3) Rescinded IAB 7/7/04, effective 7/1/04.

(4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $20,960 per month.

(5) The average statewide charge to a resident of a mental health institute is $17,758 per month.

(6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $5,044 per month.

(7) The average statewide charge to a home- and community-based waiver applicant or recipient shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible" shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Member" shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, "member" shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member."

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of assets" shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Needy specified relative" means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member's circumstances comes to the attention of a staff member.

75.52(3) *Forms.*

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) *Client responsibilities.* For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*

(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.

(2) Change of mailing or living address.

(3) Sources of income.

(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.

(2) The mailing or living address changes.

(3) A source of income changes.

(4) A health insurance premium or coverage change is effective.

(5) Of any change in income.

(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[**ARC 8260B**, IAB 11/4/09, effective 1/1/10; **ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means

the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

(2) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1)*"b"* as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)*"n"* or *"o,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)*"c"*reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)*"d"* and 75.57(7)*"ag."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"* 75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The department shall return all verification to the applicant or member.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the

difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)*"b"* and 75.57(1)*"d."*

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)*"f."*

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related

Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."*

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) *Exclusions from the eligible group.* In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) *Needs, income, and resource exclusions.* The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) *Medicaid entitlement.* Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2)*"a," "b,"* and *"c."*

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

These rules are intended to implement Iowa Code section 249A.4.

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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 subrule 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 lemphocytic 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. 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. 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]

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 panographic-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 prophylasix 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 rule 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		
		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		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		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 date of the signature shall be within the certification period.

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]

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 the mentally retarded except when a Medicaid-eligible resident of a nursing facility medically needs oxygen for 12 or more hours per day for at least 30 days or more. Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility 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 a resident of a nursing facility requires oxygen for 12 hours or more per day and the provider and physician, physician assistant, or advanced registered nurse practitioner jointly submit Certificate of Medical Necessity, Form CMS-484, from Medicare or a reasonable facsimile to the Iowa Medicaid enterprise with the monthly billing. The documentation submitted 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.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(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 shown by medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment have been tried and have not been successful, and that oxygen therapy is required.

(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:

Artificial eyes.

Artificial limbs.

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.

Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

Hearing aids. See rule 441—78.14(249A).

Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements.

Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

Ostomy appliances.

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.

Prosthetic shoes. See rule 441—78.15(249A).

Tracheotomy tubes.

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(8))

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.

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. Medical supplies are not to be dispensed at any one time for quantities exceeding a three-month supply. 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:

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]

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 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) Transportation to receive medical care. Payment will be approved for transportation to receive services covered under the program, including transportation to obtain prescribed drugs, when all of the following conditions are met.

78.13(1) Transportation costs are reimbursable only when:

a. The source of the care is located outside the city limits of the community in which the member resides; or

b. The member resides in a rural area and must travel to a city to receive necessary care.

78.13(2) Transportation costs are reimbursable only when:

a. The type of care is not available in the community in which the member resides; or

b. The member has been referred by the attending physician to a specialist in another community.

78.13(3) Transportation costs are reimbursable only when there is no resource available to the member through which necessary transportation might be secured free of charge. EXCEPTION: Costs of transportation to obtain prescribed drugs may be reimbursed irrespective of whether free delivery is offered when the prescription drug is needed immediately.

78.13(4) Transportation is reimbursable only to the nearest institution or practitioner having appropriate facilities for the care of the member.

78.13(5) Transportation may be of any type and may be provided from any source.

a. When transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 30 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed $1.40 per mile.

c. In all cases where public transportation is reasonably available to or from the source of care and the member's condition does not preclude its use, public transportation must be utilized. When the member's condition precludes the use of public transportation, a statement to the effect shall be included in the case record.

78.13(6) In the case of a child too young to travel alone, or an adult or child who because of physical or mental incapacity is unable to travel alone, payment subject to the above conditions shall be made for the transportation costs of an escort. The worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

78.13(7) When meals and lodging or other travel expenses are required in connection with transportation, payment will be subject to the same conditions as for a state employee and the maximum amount payable shall not exceed the maximum payable to a state employee for the same expenses in connection with official travel within the state of Iowa.

78.13(8) When the services of an escort are required subject to the conditions in subrule 78.13(6), payment may be made for the escort's meals and lodging, when required, on the same basis as for the member.

78.13(9) Payment will not be made in advance to a member or a provider of medical transportation.

78.13(10) Payment for transportation to receive medical care is made to the member with the following exceptions:

a. Payment may be made to the agency that provided transportation if the agency is certified by the department of transportation and requests direct payment. Reimbursement for transportation shall be based on a fee schedule by mile or by trip.

b. In cases where the local office has established that the member has persistently failed to reimburse a provider of medical transportation, payment may be made directly to the provider.

c. In all situations where one of the department's volunteers is the provider of transportation.

78.13(11) Form 470-0386, Medical Transportation Claim, shall be completed by the member and the medical provider and submitted to the local office for each trip for which payment is requested. All trips to the same provider in a calendar month may, at the member's option, be submitted on the same form.

78.13(12) No claim shall be paid if presented after the lapse of 365 days from its accrual unless it is to correct payment on a claim originally submitted within the required period.

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]

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.

a. Assignment of payment slot. The number of persons who may be approved for home- and community-based habilitation services is subject to a yearly total to be served. The total is set by the department based on available funds and is contained in the Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services. The limit is maintained through the awarding of payment slots to members applying for services.

(1) The case manager shall contact the Iowa Medicaid enterprise through ISIS to determine if a payment slot is available for each member applying for home- and community-based habilitation services.

(2) When a payment slot is assigned, the case manager shall give written notice to the member.

(3) The department shall hold the assigned payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next applicant on the waiting list, if applicable. The member must reapply for a new slot.

b. Waiting list for payment slots. When the number of applications exceeds the number of members specified in the state plan and there are no available payment slots to be assigned, the member's application for habilitation services shall be denied. The department shall issue a notice of decision stating that the member's name will be maintained on a waiting list.

(1) The Iowa Medicaid enterprise shall enter the member on a waiting list based on the date and time when the member's request for habilitation services was entered into ISIS. In the event that more than one application is received at the same time, members shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) When a payment slot becomes available, the Iowa Medicaid enterprise shall notify the member's case manager, based on the member's order on the waiting list. The case manager shall give written notice to the member within five working days.

(3) The department shall hold the payment slot for 20 calendar days to allow the case manager to reapply for habilitation services by entering a program request through ISIS. If a request for habilitation services has not been entered within 20 calendar days, the slot shall revert for use by the next member on the waiting list, if applicable. The member assigned the slot must reapply for a new slot.

(4) The case manager shall notify the Iowa Medicaid enterprise within five working days of the withdrawal of an application.

c. Notice of decision. 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.

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) A payment slot is not available to the member pursuant to paragraph 78.27(3)*"a."*

(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)]

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. Salzmann, 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) Rescinded IAB 6/4/08, effective 5/15/08.

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]

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 disrhythmia 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 MR 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.

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 are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. The interdisciplinary team shall determine if the consumer 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* 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 when the consumer is alone.

a. The required components of the system are:
(1) An in-home medical communications transmitter and receiver.
(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 consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. 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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 selected under subparagraph (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS ill and handicapped waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need

for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the following services:

(1) Assist the consumer with developing the consumer's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the consumer 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 consumer.

(5) Assist the consumer with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the consumer with obtaining a signed consent from a potential employee to conduct background checks if requested by the consumer.

(7) Assist the consumer with negotiating with entities providing services and supports if requested by the consumer.

(8) Assist the consumer with contracts and payment methods for services and supports if requested by the consumer.

(9) Assist the consumer with developing an emergency backup plan. The emergency backup plan shall also 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 consumer. Contact documentation shall include information on the extent to which the consumer's individual budget has addressed the consumer's needs and the satisfaction of the consumer.

k. 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 consumer, 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, if requested.

(6) Verify for the consumer an employee's citizenship or alien status.

(7) Assist the consumer with fiscal and payroll-related responsibilities. Key employer-related tasks include:

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) Purchase from the individual budget workers' compensation or other forms of insurance, as applicable or if requested by the consumer.

(9) Assist the consumer in completing required federal, state, and local tax and insurance forms.

(10) Establish and manage documents and files for the consumer and the consumer's employees.

(11) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each consumer for a total of five years.

(12) Provide monthly and quarterly status reports for the department, the independent support broker, and the consumer that include a summary of expenditures paid and amount of budget unused.

(13) Establish an accessible customer service system and a method of communication for the consumer and the individual support broker that includes alternative communication formats.

(14) Establish a customer services complaint reporting system.

(15) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(16) Develop a business continuity plan in the case of emergencies and natural disasters.

(17) Provide to the department an annual independent audit of the financial management service.

(18) 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.

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 are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer 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 persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 consumer'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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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.

78.37(16) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS elderly waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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]

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer 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 persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. A maximum of 14 meals is allowed per week. 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 are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) 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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS AIDS/HIV waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

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 MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR 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 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 consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

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 those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer 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 person 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" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person 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" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

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-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer 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 consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer 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 system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. 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 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 consumer'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 consumer 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 MR 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 consumer's individual comprehensive 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. 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 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 MR 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 consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, 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 consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer in the HCBS mental retardation 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS mental retardation waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.42(249A) Rehabilitative treatment services. Rescinded IAB 8/1/07, effective 9/5/07.

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 consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 those activities which assist a consumer 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 individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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 those activities which assist a consumer 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 person 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 person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer 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 those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are 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 consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 consumer 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 habilitative 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 modifications*. Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation 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.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive 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 are set forth in rule 441—171.6(234).

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 aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. 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 more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include 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 individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed

by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the

consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS brain injury waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

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) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

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 listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. 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. Consumers 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 consumer.

a. 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, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. 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 consumers 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.

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer'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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer's service plan when calculating the value of that service to be included in the individual budget.

(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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS physical disability waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

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 items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer'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 to 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 consumer 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 consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer'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 consumer. The consumer 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 consumer. The consumer 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 consumers receiving respite. These consumers 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 consumers 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 consumer'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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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.

CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

"Department" means the Iowa department of human services.

"Director" means the director of the child support recovery unit of the department or the director's designee.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Mental retardation professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the

educational requirements for the profession, as required in the state of Iowa, and has one year of experience working with persons with mental retardation.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Service area manager" means the department employee or designee responsible for managing department offices within a department service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care which require additional skill, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

"Unearned income" means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule effective January 1, 2010, to June 30, 2010:

Age of child	Daily rate
0 through 5	$15.54
6 through 11	$16.16
12 through 15	$17.69
16 or over	$17.93

156.6(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.6(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.6(4) *Difficulty of care payment.*

a. For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus $5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

b. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

c. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

d. Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

e. Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, mental health professional, or mental retardation professional, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

f. For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.75 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.50 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.25 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

156.6(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.6(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—156.7(234) Purchase of family foster care services. Rescinded IAB 5/6/09, effective 7/1/09.

441—156.8(234) Additional payments.

156.8(1) *Clothing allowance.* When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed $237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed $190 for family foster care and $100 for all other levels when:

(1) The child needs clothing to replace lost clothing or because of growth or weight change, and
(2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.8(2) *Supervised apartment living.* When a youth is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $400 if the youth does not have sufficient resources to cover initial costs.

156.8(3) *Medical care.* When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

156.8(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid

program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.8(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.8(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed $5 may be authorized by the department worker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or a mental retardation professional has recommended school attendance.

156.8(7) *Respite care.* The service area manager or designee may authorize respite for a child in family foster care for up to 24 days per calendar year per placement. Respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—156.9(234) Rate of payment for foster group care.

156.9(1) *In-state reimbursement.* Effective November 1, 2006, public and private foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with the rate-setting methodology in this subrule.

a. A provider of group care services shall maintain at least the minimum staff-to-child ratio during prime programming time as established in the contract. Staff shall meet minimum qualifications as established in 441—Chapters 114 and 115. The actual number and qualifications of the staff will vary depending on the needs of the children.

b. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

c. Reimbursement rates shall be adjusted based on the provider's rate in effect on October 31, 2006, to reflect an estimate that group care providers will provide an average of one hour per day of group remedial services and one hour per week of individual remedial services. The reimbursement rate shall be calculated as follows:

(1) Step 1. Annualize the provider's combined daily reimbursement rate for maintenance and service in effect on October 31, 2006, by multiplying that combined rate by 365 days.

(2) Step 2. Annualize the provider's remedial services reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

(3) Step 3. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

(4) Step 4. Add the amounts determined in Steps 2 and 3.

(5) Step 5. Subtract the amount determined in Step 4 from the amount determined in Step 1.

(6) Step 6. Divide the amount determined in Step 5 by 365 to compute the new combined maintenance and child welfare service per diem rate.

(7) Step 7. Determine the maintenance portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 85.62 percent.

(8) Step 8. Determine the child welfare service portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 14.38 percent.

EXAMPLE: Provider A has the following rates as of October 31, 2006:

- A combined daily maintenance and service rate of $121.45;
- A Medicaid rate for service code 96153 of $5.10 per 15 minutes, or $20.40 per hour;
- A Medicaid rate for service code 96152 of $19.92 per 15 minutes, or $79.68 per hour.

Step 1. $121.45 × 365 days = $44,329.25
Step 2. $20.40 × 365 days = $7,446.00
Step 3. $79.68 × 52 weeks = $4,143.36
Step 4. $7,446.00 + $4,143.36 = $11,589.36
Step 5. $44,329.25 - $11,589.36 = $32,739.89
Step 6. $32,739.89 ÷ 365 days = $89.70
Step 7. $89.70 × 0.8562 = $76.80 maintenance rate
Step 8. $89.70 × 0.1438 = $12.90 child welfare service rate
Provider A's rates are $76.80 for maintenance and $12.90 for child welfare services.

d. No less than annually, the department shall redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions based on review of verified remedial services cost reports for foster group care services providers. If the new allocation differs from the current allocation, the department shall:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates and the effective date.

156.9(2) *Out-of-state group care payment rate.* The payment rate for maintenance and child welfare services provided by public or private agency group care licensed or approved in another state shall be established using the same rate-setting methodology as that in subrule 156.9(1), unless the director determines that appropriate care is not available within the state pursuant to the following criteria and procedures.

a. Criteria. When determining whether appropriate care is available within the state, the director shall consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service fund or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. Procedure. The service area manager or chief juvenile court officer shall submit the request for director's exception to the Bureau of Policy Analysis, Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in 156.9(2)*"a."*

c. Appeals. The decision of the director regarding approval of an exception to the rate determination in rule 441—152.3(234) is not appealable.

156.9(3) *Supplemental payments for in-state facilities.* Rescinded IAB 9/1/93, effective 8/12/93.

156.9(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, the maintenance rate for the mother shall include an additional amount to cover the actual and allowable maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

a. The rate shall be determined according to the policies in rule 441—152.3(234) and added to the maintenance rate for the mother. The young child portion of the maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

b. Rescinded IAB 6/8/94, effective 6/1/94.

c. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

d. The facility shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or general education equivalent (GED).

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

e. The agency shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a GED program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

f. The agency shall designate $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8715B**, IAB 5/5/10, effective 7/1/10]

441—156.10(234) Payment for reserve bed days.

156.10(1) *Group care facilities.* The department shall provide payment for group care maintenance and child welfare services according to the following policies.

a. Family visits. Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the worker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility shall be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Runaways. Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.

(3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.10(2) *Foster family care.*

a. Family visits. Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

b. Hospitalization. Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. Runaways. Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home shall be for the child to return to the foster family home.

(3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(4) Payment shall not exceed two consecutive days.

156.10(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.11(234) Emergency care.

156.11(1) and **156.11(2)** Rescinded IAB 3/11/09, effective 5/1/09.

156.11(3) Shelter care payment. Public and private juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the rate-setting methodology in 441—paragraph 150.3(5)*"p."*

a. Facilities shall bill for actual units of service provided in accordance with 441—subrule 150.3(8). In addition, facilities may be guaranteed a minimum level of payment to the extent determined by the department through a request-for-proposal process.

(1) Guaranteed payment shall be calculated monthly.

(2) The guaranteed level of payment shall be calculated by multiplying the number of beds for which payment is guaranteed by the number of days in the month.

(3) When the actual unit billings for a facility do not equal the guaranteed level of payment for the month, the facility may submit a supplemental billing for the deficiency.

(4) The amount of the supplemental billing shall be determined by multiplying the facility's unit cost for shelter care by the number of units below the guaranteed level for the month for which the facility was not reimbursed.

b. The total reimbursement to the agency shall not exceed the agency's allowable costs as defined in 441—subrule 150.3(5). Agencies shall refund any payments which have been made in excess of the agencies' allowable costs.

c. Shelter contracts for the state fiscal year beginning July 1, 2007, shall provide for the statewide availability of a daily average of 273 guaranteed emergency juvenile shelter care beds during the fiscal year.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09]

441—156.12(234) Supervised apartment living.

156.12(1) *Maintenance.* When a youth at least aged 16 but under the age of 20 is living in a supervised apartment living situation, the maximum monthly maintenance payment for the youth shall be $573.90. This payment may be paid to the youth or another payee, other than a department employee, for the youth's care.

156.12(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10]

441—156.13(234) Excessive rates. Rescinded IAB 6/9/93, effective 8/1/93.

441—156.14(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

441—156.15(234) Child's earnings. Earned income of a child who is not in a supervised apartment living arrangement and who is a full-time student or engaged in an educational or training program shall be reported to the department and its use shall be a part of a plan for service, but the income shall not be used towards the cost of the child's care as established by the department. When the earned income of children in supervised apartment living arrangements or of other children exceeds the foster care standard, the income in excess of the standard shall be applied to meet the cost of the child's care. When the income of the child exceeds twice the cost of maintenance, the child shall be discontinued from foster care.

441—156.16(234) Trust funds and investments.

156.16(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

156.16(2) The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

156.16(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.17(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.18(237) Foster parent training expenses. Rescinded IAB 7/29/09, effective 10/1/09.

441—156.19(237) Rate of payment for care in a residential care facility. When a child is receiving group care maintenance and child welfare services in a licensed residential care facility and is not eligible for supplemental security income or state supplementary assistance, the department will pay for the group care maintenance and child welfare services in accordance with subrule 156.9(1). When a child receives group care maintenance and child welfare services in a licensed residential care facility and is eligible for supplemental security income or state supplementary assistance, the department will pay for child welfare services in accordance with subrule 156.9(1).

This rule is intended to implement Iowa Code section 237.1(3)*"e."*

441—156.20(234) Eligibility for foster care payment.

156.20(1) *Client eligibility.* Foster care payment shall be limited to the following populations.

a. Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52, subsection 2, paragraph *"d,"* Iowa Code section 232.102, subsection 1, Iowa Code section 232.117, or Iowa Code section 232.182, subsection 5.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20, subsection 1, or Iowa Code section 232.21.

3. The department has agreed to provide foster care pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements which have been authorized by the department and which conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria. The child's eligibility for the exception shall be documented in the case record.

1. The child does not have mental retardation. Funding for services for persons with mental retardation is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds which may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area's funding allocation shall be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in subrule 156.6(4), paragraph *"a,"* and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.20(2) *Provider eligibility for payment.*

a. Providers of shelter care services and supervised apartment living services shall have a purchase of service contract under 441—Chapter 150 in force.

b. Providers of group care services shall have a foster group care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

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CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT
[Prior to 2/11/87, Human Services [498]]

DIVISION I
ANNUAL REIMBURSEMENT PROGRAM

441—167.1(232) Definitions.

"Allowable costs" means those expenses of the county or multicounty related to the establishment, improvements, operation, and maintenance of county or multicounty juvenile detention homes.

"County or multicounty" means that the governing body is a county board of supervisors or a combination of members of participating county boards of supervisors.

"Eligible costs" are those allowable costs that are directly attributable to the function of detaining youth in the home, from the point of intake through discharge from the home, as further defined in subrule 167.3(3).

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.2(232) Availability of funds. Any year that the Iowa legislature makes funds available for this program, the department shall accept requests for reimbursement from eligible facilities.

441—167.3(232) Eligible facilities. County and multicounty juvenile detention homes shall be eligible for reimbursement under this program when:

167.3(1) The home is approved by the department under the standards of Iowa Code chapter 232 and IAC 441—Chapter 105.

167.3(2) The home submits the following by May 15 of the year following the conclusion of the state fiscal year for which reimbursement will be made:

a. A written statement delivered in printed form or via electronic mail identifying the eligible total net cost that will be claimed under rule 441—167.5(232).

b. A printed or electronic copy of the following sections of Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts:

(1) Certification page.

(2) Schedule A, Revenue Report.

(3) Schedule C, Property and Equipment Depreciation and Related Party Property Costs.

(4) Schedule D, Expense Report.

c. A printed or electronic copy of the home's certified audit containing financial information for the period for which reimbursement is being claimed.

167.3(3) The department has reviewed the information submitted and determined that the costs to be claimed meet eligibility requirements. Eligible costs shall be determined by using a cost allocation methodology that follows generally accepted accounting principles (GAAP). Eligible costs shall be based on the portions of the allowable costs that are directly attributable to the function of detaining youth in the home.

a. Costs are not eligible for reimbursement if a supplemental funding, reimbursement, or refund source is available to the home. County payments to an eligible home for the function of detaining youth in the home ("care and keep") are not considered to be supplemental funding, reimbursement, or refund sources for the purpose of this subrule. Ineligible costs include, but are not limited to:

(1) Refundable deposits.

(2) Services funded by sources other than the juvenile detention reimbursement program.

(3) Operational activities such as the food and nutrition program that is funded by the Iowa department of education.

b. Costs attributed to portions of the home not directly used for detaining children are not eligible for reimbursement.

c. Costs of alternatives to detaining youth in the approved detention home are not eligible for reimbursement. Services ineligible for reimbursement include, but are not limited to:

(1) Community tracking and monitoring activities.
(2) Transportation not related to detention.
(3) Outreach services.
(4) In-home detention.

d. Capital expenses shall be depreciated over the useful life of the item following generally accepted accounting principles. The annual depreciated amount for items that are eligible costs may be claimed for reimbursement.

(1) Capital expenses shall include items costing more than $5,000 that have a useful life of over two years.
(2) Depreciation schedules shall be filed annually as needed.

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.4(232) Available reimbursement. The reimbursement for the participating facilities shall be the percentage of the allowable costs authorized in the appropriation language for the current fiscal year.

441—167.5(232) Submission of voucher. Eligible facilities shall submit a complete signed and dated Form GAX, General Accounting Expenditure, to the department to claim reimbursement.

167.5(1) Form GAX shall be submitted to the Department of Human Services, Division of Fiscal Management, First Floor, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, by August 10.

167.5(2) The form shall include the total net eligible costs incurred between July 1 and June 30 of the year covered by the reimbursement. The total net eligible costs will be used to calculate the legislatively authorized percentage of the home's allowable costs for the year covered by the reimbursement.

167.5(3) Only facilities that submit Form GAX by August 10 shall receive reimbursement.

[**ARC 8716B**, IAB 5/5/10, effective 7/1/10]

441—167.6(232) Reimbursement by the department. Reimbursement shall be made by August 31 to those participating facilities which have complied with these rules.

These rules are intended to implement Iowa Code section 232.142.

441—167.7 to **167.10** Reserved.

DIVISION II
SEVENTY-TWO HOUR REIMBURSEMENT PROGRAM

Reserved

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CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care in their successful transition to adulthood. The aftercare program, including the preparation for adult living (PAL) component, helps former foster care youth to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program also offers financial benefits to eligible youth up to the age of 21. All services and supports are voluntary.

DIVISION I
AFTERCARE SERVICES

441—187.1(234) Purpose. The purpose of aftercare services is to provide services and supports to youth aged 18, 19 or 20 who were formerly in foster care. The primary goal of the program is for participants to achieve self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

441—187.2(234) Eligibility. To be eligible for aftercare services, a youth must meet the following requirements:

187.2(1) *Residence.* The youth must reside in Iowa.

187.2(2) *Age.* The youth must be at least 18 years of age but less than 21 years of age.

187.2(3) *Foster care experience.*

a. The youth must leave foster care:

(1) On or after the youth's eighteenth birthday; or

(2) Between the ages of 17½ and 18 after being in foster care continuously for at least six months; or

(3) For placement in a subsidized guardianship arrangement on or after October 7, 2008, and on or after the youth's sixteenth birthday; or

(4) Due to adoption on or after October 7, 2008, and on or after the youth's sixteenth birthday.

b. For purposes of this division, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either court order or voluntary agreement.

c. A placement may meet the definition of foster care regardless of whether:

(1) The placement is licensed and the state or a local agency makes payments for the child's care;

(2) Adoption subsidy payments are being made before the finalization of adoption; or

(3) There is federal matching of any payments made.

d. Foster care may include, but is not limited to, placement in:

(1) A foster family home;

(2) A foster home of relatives;

(3) A group home;

(4) An emergency shelter;

(5) A preadoptive home;

(6) A residential facility; or

(7) The home of an unlicensed relative or suitable person.

(8) A psychiatric medical institution for children (PMIC).

e. Foster care does not include placement in:

(1) A detention facility;

(2) A forestry camp;

(3) A training school; or

(4) Any other facility operated primarily for the detention of children who are determined to be delinquent.

187.2(4) *Responsibility.* The youth must:

a. Actively take part in developing and participating in a self-sufficiency plan; and

b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency.

[**ARC 8717B**, IAB 5/5/10, effective 7/1/10]

441—187.3(234) Services and supports provided. The aftercare program shall provide the following services and supports to eligible youth:

187.3(1) *Individual self-sufficiency plan.* Each youth shall have an individual self-sufficiency plan based on an assessment of the youth's strengths and needs. The plan shall identify:

a. The youth's goals for achieving self-sufficiency;

b. The target date for reaching the goals; and

c. The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

187.3(2) *Life skills services.* The program shall provide life skills services to enable youth to maintain a safe, healthy, and stable home.

187.3(3) *Vendor payments.* The program shall make vendor payments to meet direct expenses of the participant that are necessary in order to meet goals of the participant's self-sufficiency plan.

a. Need. To receive a vendor payment, the youth must demonstrate that there are no other means to meet these needs. Youth receiving a PAL stipend are not eligible for a vendor payment.

b. Scope. Vendor payments may include but are not limited to:

(1) Life skills training;

(2) Transportation assistance;

(3) Employment and education assistance;

(4) Clothing; and

(5) Room and board.

c. Maximum payment. The amount available for a 12-month period of service shall not exceed $1200 per youth.

187.3(4) *Follow-up.* The program shall maintain individual face-to-face contact with the youth at a frequency as defined in the youth's self-sufficiency plan to ensure that the youth is meeting the goals of the plan.

187.3(5) *Ongoing assessment.* Ongoing assessment activities shall be directed toward:

a. Monitoring the progress being made in the youth's ability to achieve self-sufficiency; and

b. Coordination and evaluation of the services and supports being provided to reach the self-sufficiency goal.

187.3(6) *Case management.* Case management activities shall include, but not be limited to:

a. Community involvement services to enable the youth to access community resources; and

b. Development of support systems, including services to assist the youth in establishing or reestablishing relationships with significant adults.

441—187.4(234) Termination. Aftercare services and supports shall be terminated when any of the following conditions apply:

187.4(1) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator.

187.4(2) The youth voluntarily withdraws from aftercare services.

187.4(3) The youth is no longer residing in Iowa.

187.4(4) The youth reaches 21 years of age.

187.4(5) There are insufficient funds to continue the services.

441—187.5(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.6(234) Administration. The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer this program.

187.6(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)*"i."*

187.6(2) Agencies providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

441—187.7 to **187.9** Reserved.

These rules are intended to implement Iowa Code section 234.6 and Public Law 106-169, the Foster Care Independence Act of 1999.

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

441—187.10(234) Purpose. The purpose of the PAL program is to provide financial support to eligible youth who are receiving aftercare services. Youth receiving a PAL stipend are not eligible to receive aftercare vendor payments.

441—187.11(234) Eligibility. A monthly stipend may be provided to a youth receiving aftercare services who left foster care after May 1, 2006, and who meets all of the following criteria:

187.11(1) *Ineligibility for foster care.* The youth must be ineligible for voluntary foster care placement under 441—Chapter 202.

187.11(2) *Foster care experience.* The youth must:

a. Leave foster care paid for by the state under Iowa Code section 234.35 on or after the youth's eighteenth birthday; and

b. Have been in foster care paid for by the state under Iowa Code section 234.35 in at least 6 of the last 12 months before the youth left foster care.

187.11(3) *Living arrangement.* The youth must have a living arrangement other than a parent's home, which may include a former foster family, an apartment, a college dormitory, or another approved arrangement. The program administrator or designee is responsible for approving the living arrangement.

187.11(4) *Activity.* The youth must meet one or more of the following criteria:

a. Be enrolled in or actively pursuing enrollment in a postsecondary education or training program or work training;

b. Be employed for 80 hours per month or be actively seeking that level of employment; or

c. Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or

d. Be attending an instructional program leading to a high school equivalency diploma.

187.11(5) *Financial need.* Initial and ongoing eligibility shall be based on the youth's income and need as determined according to rule 441—187.12(234).

[**ARC 8717B**, IAB 5/5/10, effective 7/1/10]

441—187.12(234) Payment. The program administrator or designee shall issue payment to each participant according to the following guidelines:

187.12(1) *Need.* The amount of the PAL stipend shall be based on the needs of the youth as documented in the youth's self-sufficiency plan. Eligibility and the stipend amount shall be based on the best estimate of the youth's income, as determined at least quarterly.

a. All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income.

(1) If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments include but are not limited to one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as SSI, unemployment insurance, or public assistance.

b. The youth shall timely report the beginning or ending of earned or unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

c. When the youth timely reports a change in income, prospective eligibility and stipend amount for the following month shall be determined based on the change.

d. Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment shall be done through a reasonable reduction of any future stipends.

e. Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—7.7(17A) requires that the action be delayed until the second calendar month following the month of change.

187.12(2) *Amount of monthly stipend.* The maximum monthly stipend shall be $574.

a. The stipend shall be prorated based on the date of entry.

b. Effect of income.

(1) When the monthly unearned income of the youth exceeds the maximum monthly stipend, the youth is not eligible for a stipend.

(2) When the net earnings of the youth exceed the maximum monthly stipend, the stipend shall be reduced the following month by 50 cents for every dollar earned over the maximum monthly stipend.

(3) A youth receiving Supplemental Security Income payments is not eligible for a stipend.

187.12(3) *Payee.* The PAL stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the self-sufficiency plan under 187.3(1).

187.12(4) *Start-up allowance.* When a youth is approved for the PAL program, the program administrator or designee may authorize a one-time start-up allowance in addition to the monthly stipend. The start-up allowance:

a. Is intended to assist in covering the initial costs of establishing the youth's living arrangement, such as rental and utility deposits, purchase of food, and purchase of necessary household items.

b. Shall be based on the youth's income and need as determined according to subrule 187.12(1).

c. Shall not exceed the maximum monthly stipend amount.

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8717B**, IAB 5/5/10, effective 7/1/10]

441—187.13(234) Termination of stipend. The PAL stipend shall be terminated when any of the following conditions apply:

187.13(1) The youth reaches the age of 21.

187.13(2) The youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

187.13(3) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator or designee.

187.13(4) The youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program by choosing the work option.

187.13(5) The youth chooses to live in a nonapproved setting.

187.13(6) The youth no longer resides in Iowa.

187.13(7) The youth lives with a parent.

187.13(8) There are insufficient funds to continue the stipend.

441—187.14(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the PAL program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.15(234) Administration. The department may contract with another state agency or a private organization to perform the administrative functions necessary to administer the PAL program.

187.15(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)*"i."*

187.15(2) Agencies providing support or services shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

These rules are intended to implement Iowa Code section 234.46.

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CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

[Prior to 7/1/83, Social Services[770] Ch 136]
[Previously appeared as Ch 136—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—202.1(234) Definitions.

"Case permanency plan" shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved and reviewing progress.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Department" shall mean the Iowa department of human services and includes the local offices of the department.

"Eligible child" shall mean a child for whom the court has given guardianship to the department or has transferred legal custody to the department or for whom the department has agreed to provide foster care services on the basis of a signed placement agreement or who has been placed in emergency care for a period of not more than 30 days upon the approval of the director or the director's designee.

"Facility" means the personnel, program, plant and equipment of a person or agency providing child foster care.

"Family safety, risk, and permanency service" means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

"Foster care" shall mean substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision, and health care.

"Natural parent" shall mean a parent by blood, marriage, or adoption.

"Person" or *"agency"* shall mean individuals, institutions, partnerships, voluntary associations, and corporations, other than institutions under the management or control of the department, who are licensed by the department as a foster family home, child caring agency or child placing agency, or approved as a shelter care facility.

"Resource family" means an individual person or married couple who is licensed to provide foster family care or approved for adoption.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Service area manager" shall mean the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social history" or *"child study"* means a written description of the child that includes strengths and needs; medical, mental, social, educational, placement and court history; and the child's relationships with the birth family and significant others.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.2(234) Eligibility.

202.2(1) Only an eligible child as defined in these rules shall be considered for foster care services supervised by the department.

202.2(2) The need for foster care placement and social and other related services, including but not limited to medical, psychiatric, psychological, and educational services, shall be determined by an assessment of the child and family to determine their needs and the appropriateness of services.

a. Assessments shall include:

(1) The educational, physical, psychological, social, family living, and recreational needs of the child,

(2) The family's ability to meet those needs, and

(3) A family genogram to determine relatives and other suitable support persons who have a kinship bond with the child.

b. The assessment is a continual process to identify needed changes in service or placement for the child.

202.2(3) With the exception of emergency care, a social history shall be completed on each child before a department recommendation for foster care placement, using the outline RC-0027, Social History Format.

a. For voluntary emergency placements, a social history shall be completed before a decision is made to extend the placement beyond 30 days.

b. For court-ordered emergency placements, a social history shall be completed before the disposition hearing.

202.2(4) Foster care placement shall be recommended by the department only after efforts have been made to prevent or eliminate the need for removal of the child from the family unless the child is in immediate danger at home.

202.2(5) The need for foster care and the efforts to prevent placement shall be evaluated by a review committee prior to placement or, for emergency placements only, within 30 days after the date of placement. For children who are mentally retarded or developmentally disabled and receive case management services, this requirement may be met by the interdisciplinary staffing described in 441—Chapter 90, as long as the service area manager approves, the department worker attends the staffing, and the staffing meets the requirements of paragraphs *"b"* to *"h"* below.

The review shall meet the following requirements:

a. Department staff on the review committee shall be the child's service worker, a supervisor knowledgeable in child welfare, and one or more additional persons appointed by the service area manager.

b. The review shall be open to the participation of the parents or guardian of the child, local and area education staff, juvenile court staff, the guardian ad litem, current service providers and previous service providers who have maintained a license.

c. The present foster care provider, if any, shall be notified of the review and have the opportunity to participate.

d. Written notice of the review shall be sent to the child's parents or guardian at least five working days prior to the date of the review.

e. Other persons may be invited to the review with the consent of the parents or guardian.

f. A written summary of the review recommendations shall be sent to the child's parents or guardian following the review.

g. Review committee recommendations shall be advisory to the service worker and supervisor, who are responsible for development of the department case plan and for reports and recommendations to the juvenile court.

h. At least one of the persons on the review committee shall be someone without responsibility for the case management or the delivery of services to either the child or the parents or guardian who are the subject of the review.

202.2(6) The citizenship or alien status of a child who enters foster care must be verified.

a. When the child will remain in foster care for no more than 60 days, Form 470-4500, Statement of Citizenship Status: Foster Care, signed by the parent or guardian of the child is sufficient.

b. When the child will remain in foster care for more than 60 days, one of the documents listed in this paragraph is required. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A certificate of birth in the United States.

(2) Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

(3) Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

(4) A United States passport.

(5) Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

(6) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(7) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(8) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(9) Another document that provides proof of United States citizenship or nationality as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v) or 1396b(x)(3)(C)(v).

c. A child entering foster care is exempt from these requirements when the family has previously presented satisfactory documentary evidence of citizenship, as specified by the Secretary of the U.S. Department of Health and Human Services.

d. The parent or guardian of the child shall have a reasonable period to obtain and provide proof of citizenship. For the purposes of this requirement, the "reasonable period" begins on the date when the child is placed in foster care and continues to the date when the proof is provided or when the department establishes that the parent or guardian is no longer making a good-faith effort to obtain the proof.

This rule is intended to implement Iowa Code sections 234.6(1) and 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.3(234) Voluntary placements.

202.3(1) All voluntary placement agreements initiated after July 1, 2003, for children under the age of 18 shall terminate after 90 days.

202.3(2) When the voluntary placement is of a child who is under the age of 18, a Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

202.3(3) Voluntary placement of a child aged 18 or older may be granted for six months at a time.

a. The department shall enter into the agreement only when the child:

(1) Meets the definition of "child" in Iowa Code section 234.1,

(2) Was in foster care or a state institution immediately before reaching the age of 18,

(3) Has continued in foster care or a state institution since reaching the age of 18,

(4) Has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case permanency plan, and

(5) Will be placed in foster family care or supervised apartment living in Iowa.

b. Payment shall be limited pursuant to 441—paragraph 156.20(1)*"b."*

c. When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the guardian and the local office where the guardian resides. Voluntary Foster Care Placement Agreements shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

d. When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the child and the local office where the child resides.

e. An exception to the requirement for continuous placement may be made for a youth who leaves foster care at age 18 and voluntarily returns to supervised apartment living foster care before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED).

202.3(4) All voluntary placements shall be approved by the service area manager or designee.

This rule is intended to implement Iowa Code sections 234.6(6)*"b"* and 234.35(1)*"c."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.4(234) Selection of facility.

202.4(1) Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

202.4(2) Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

202.4(3) The department shall first consider placing the child in a relative's home unless no relatives are available or willing to accept placement or such placement would be detrimental to the child's physical, emotional or mental well-being.

a. If a relative or a suitable person who has a kinship bond with the child will accept placement of the child:

(1) The person shall sign Form 595-1489, Non-Law Enforcement Record Check Request, and

(2) The department shall complete record checks as listed in 441—subrule 113.13(1) to evaluate if the person's home is appropriate for the child before making the placement.

b. Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

202.4(4) If the child cannot be placed with a relative or a suitable person who has a kinship bond with the child, foster family care shall be used for a child unless the child has problems which require specialized services that cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

202.4(5) A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

a. The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

b. The child's individual problems, medical needs, and plans for future care. The department shall not place a child with asthma or other respiratory health issues in a foster home where any member of the household smokes.

c. The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

d. The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

e. An environment that will cause minimum disruption of the child including few changes in placement for the child.

f. Rescinded IAB 4/11/07, effective 7/1/07.

202.4(6) A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current contract with the department pursuant to 441—Chapter 152.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.5(234) Preplacement.

202.5(1) Except for placements made in less than 24 hours, a child placed in a facility shall have a preplacement visit involving:

a. The child,

b. The foster parents or agency staff, if the child is placed in a public or private agency,

c. The department service worker, and

d. The child's parents, unless their presence would be disruptive to the child's placement.

202.5(2) Before placement, the worker shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns including safety-related information, educational plans, and permanency goal. Safety-related information shall be withheld only if:

a. Withholding the information is ordered by the court; or

b. The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.5(3) The child shall have a physical examination by a physician before the initial placement in foster care or within 14 calendar days of placement. The physician shall complete a preliminary screening for dental and mental health and refer the child to a dentist or mental health professional if appropriate. To address any immediate medical needs, the child shall be seen immediately at an emergency room, an urgent care center, or other community health resource.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.6(234) Placement.

202.6(1) At the time of placement, the department worker shall furnish to the foster care provider any available information regarding the child.

a. The information provided shall include:

(1) The child's full name and date of birth;

(2) The names, work addresses, and telephone numbers of the placement worker and the worker's supervisor, including a home telephone, cell phone, or on-call number;

(3) The names, addresses, and telephone numbers of the child's physician and dentist;

(4) The names, addresses, and telephone numbers of significant relatives of the child, including parents, grandparents, brothers and sisters, aunts and uncles, and any other significant persons (for an adopted child, the adoptive parents and adoptive relatives);

(5) The case permanency plan;

(6) The results of a physical examination, including immunization history;

(7) The child's medical needs including allergies, physical limitations, dental and medical recommendations, and special needs of HIV;

(8) Behavioral patterns including safety-related information;

(9) Educational arrangements including, but not limited to, the school the child attends, special education needs, and school contacts;

(10) The placement contract or agreement including the date of acceptance for care;

(11) Medical authorizations, service authorizations, and other releases as needed; and

(12) If the child is an Indian, the identification of the child's tribe and tribal social service agency including telephone number and contact person.

b. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

(1) The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

(2) Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

c. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.6(2) For each foster care placement in a foster family home supervised directly by department staff, Form 470-0716 or 470-0716(S), Foster Family Placement Contract, shall be completed by the foster family and the placement worker and supervisor. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

202.6(3) A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

202.6(4) The case permanency plan shall be reviewed at least every six months to ensure appropriateness of the child's placement. A copy of the subsequent case plan shall be submitted to the court every six months unless the court orders a different frequency for reports.

202.6(5) In conjunction with the case plan review, the case shall be presented every six months to a review committee which conforms to the requirements in subrule 202.2(5). The service area manager may also approve a review by a local foster care review board authorized in Iowa Code section 237.19 or the court as meeting this requirement as long as the review conforms to subrule 202.2(5), paragraphs *"b"* to *"h,"* and to subrule 202.6(5), paragraphs *"a"* to *"e."* The review committee shall:

a. Evaluate the continuing necessity for foster care placement.

b. Evaluate the continuing appropriateness of the foster care placement.

c. Evaluate the extent of compliance with the case plan.

d. Evaluate the extent of progress made toward lessening the causes for foster care placement.

e. Project a likely date by which the child will leave foster care.

This rule is intended to implement Iowa Code sections 234.6(6)*"b,"* and 237.19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.7(234) Out-of-area placements.

202.7(1) When the department makes a placement of a child in the foster care system out of the service area in which the child resides, this placement shall occur only when there is no appropriate placement within the service area, when the placement is necessary to facilitate reunification of the child with the parents, or when an out-of-area agency is closer to the community where the child resides than an in-area agency offering the same services.

202.7(2) The authority for approving out-of-area placements rests with both the placing and receiving service area managers.

202.7(3) Transfer of responsibility for supervision, planning, and visitation shall be approved by the placing and receiving service area managers and, when appropriate, by the court.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.8(234) Out-of-state placements.

202.8(1) The department shall make an out-of-state foster family care placement only with the approval of the service area manager or designee. Approval shall be granted only when the placement will not interfere with the goals of the child's case permanency plan and when one of the following conditions exists:

a. The foster family with whom the child is placed is moving out of state.

b. An out-of-state family having previous knowledge of the child desires to provide foster care to the child.

c. An out-of-state family is approved to adopt the child under subsidy and is eligible to receive maintenance payments until the adoption is final.

d. An out-of-state placement is necessary to facilitate reunification of the child with the parents.

202.8(2) Placements shall be made in an out-of-state group care facility only with the approval of the service area manager or designee.

202.8(3) All out-of-state placements shall be made pursuant to interstate compact procedures.

202.8(4) The reasons for selecting an out-of-state placement shall be documented in the child's case permanency plan.

202.8(5) Regional out-of-state placement committees. Rescinded IAB 7/6/94, effective 7/1/94.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.9(234) Supervised apartment living. A supervised apartment living arrangement shall provide a youth with an environment in which the youth can experience living in the community with supervision. This arrangement shall prepare the youth for self-sufficiency. It is an arrangement where the youth lives in an apartment unit, shops for food, prepares individual meals, and manages time for cleaning and laundry. It is not a structured living arrangement where life skills are learned through simulated activities.

202.9(1) *Eligibility.* To be eligible for supervised apartment living placement, a youth shall meet all of the following conditions:

a. Be at least 16 years old. If aged 18 or older, the youth shall:

(1) Meet the definition of a child in Iowa Code section 234.1; and

(2) Have been in foster care or state institutional placement immediately before reaching the age of 18, and have continued in foster care or a state institution since reaching the age of 18. The service area manager or designee may waive the requirement for continuous placement for a youth who leaves foster care at age 18 and voluntarily returns before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED), consistent with Iowa Code sections 234.35(1)*"f"* and 234.35(3)*"c."*

b. If under the age of 18, either be working (or in work training) full-time or be attending high school, GED classes, or postsecondary classes and working (or in work training) part-time. If aged 18 or older, the youth shall be attending high school or GED classes and making satisfactory progress toward completion of the high school or GED program and working (or in work training) part-time. "Work training" includes individualized programs developed specifically to meet the youth's employment needs. Waiver of the work or work training requirement may be allowed with the prior approval of the service area manager or designee if:

(1) The youth can demonstrate involvement in some alternative daily activity that promotes self-sufficiency; and

(2) The waiver is in the youth's best interest.

c. Need foster care placement and services, based on an assessment completed according to rule 441—202.2(234) and subrule 202.6(5).

d. Participate in activities and services to achieve self-sufficiency.

e. Have capacity to live in the community with less supervision than that provided by a foster family or group care setting, as determined by an assessment that reviews available information on the youth to identify the needs, strengths, and resources of the youth, especially as they pertain to the youth's ability to function in the community.

f. Have an approved living situation that meets the following minimum standards:

(1) Be located so as to provide reasonably convenient access to schools, places of employment, or services required by the youth.

(2) Comply with applicable state and local zoning, fire, sanitary and safety regulations.

(3) Be reasonably priced so as to fit within the youth's budget.

g. Have the approval of the service area manager or designee.

h. If under age 18, have the approval of the juvenile court.

202.9(2) *Services to be provided.*

a. Required services. The following activities are required:

(1) Through visits with the youth and to the living situation, determination that:

1. There is no reasonable cause for believing that the youth's living situation presents any unacceptable risks to the youth's health or safety;

2. The living situation is maintained in a reasonably safe condition;

3. The youth is receiving any necessary medical care; and

4. The current program plan provides appropriate and sufficient services and supports.

(2) Supervision to assist the youth in developing the needed structure to live in this setting and in locating and using other needed services. If the youth is under age 18, supervision shall include a minimum of weekly face-to-face contacts. For youth aged 18 or older, supervision shall include a minimum of biweekly face-to-face contacts. Supervision may include guidance, oversight, and behavior monitoring.

(3) Ongoing assessment activities directed toward monitoring the progress being made in the youth's ability to achieve self-sufficiency and coordination and evaluation at least every 90 days to monitor the services and supports being provided to reach this goal.

(4) If services are purchased, visits by the department to the youth according to subrule 202.11(2).

(5) If services are purchased, compliance by the provider with all reporting requirements in 441—paragraph 150.3(3)*"j,"* including requirements for the individual service plan, quarterly reports, and a termination summary.

(6) A review of the case and case plan every six months, in accordance with subrules 202.6(4) and 202.6(5).

b. Optional services. The following services may be provided to a youth depending on the needs described in the youth's case permanency plan.

(1) Counseling services to reduce stress and severe social, emotional, or behavioral problems that affect the youth's stability or ability to achieve self-sufficiency.

(2) Leisure time and recreational services to enhance the youth's ability to develop recreational, social, leisure time or hobby, and cultural skills.

(3) Parent skill development services to train or educate youth who are parents or prospective parents to enable them to meet the needs of their children.

(4) Basic living skills services to enable or train the youth to maintain a safe, healthy, and stable home.

(5) Educational tutoring and vocational services to enable the youth to secure and maintain paid employment.

(6) Community involvement services to enable the youth to access community resources and to develop support systems, including services to assist the youth in establishing or reestablishing relationships with significant adults.

202.9(3) *Living arrangements.*

a. There are two types of supervised apartment living arrangements as follows:

(1) Scattered site arrangements have no specific site or building which houses the program. Youth are assisted by staff people in locating apartments scattered throughout the community. Up to three youths supervised by one agency may reside in apartments located in one building. Youths living in such an arrangement shall be able to contact supervising agency staff 24 hours a day, seven days a week.

(2) Cluster arrangements are those in which four to six youths reside in apartments located in one building and are supervised by one agency. Cluster arrangements shall have an adult employed by the agency on-site at any time that more than one youth is present in the cluster arrangement.

b. There shall be no provision of a meal or meals, either individually or as congregate dining, by the landlord as an inherent part of the living arrangement. This provision does not apply to youth under the age of 18 who are living in a postsecondary dormitory setting when that living arrangement best meets their needs.

c. If an agency rents an apartment to the youth, there shall be a signed lease between both parties that includes, but is not limited to:

(1) Amount to be paid for rental unit.

(2) Term of lease with both a beginning and ending date.

(3) Rights and responsibilities of tenant.

(4) Rights and responsibilities of landlord.

(5) Conditions under which lease can be terminated.

202.9(4) *Method of service provision.*

a. Supervised apartment living services may be provided directly by the department or may be purchased from a licensed child-placing agency. If services are purchased, department staff shall be responsible to determine the specific service components and the number of hours to be provided. The department case permanency plan shall specify the goals of the services that are being purchased.

b. If services are purchased, service billings shall be based on one hour, or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), of:

(1) Direct face-to-face contact between the service provider and the youth.

(2) Activities undertaken to assist the youth with the use of community resources and to consult and collaborate on service directions with schools, employers, landlords, volunteers, extended family members, peer support groups, training resources, or other community resources on behalf of the youth.

c. If services are purchased, expenses of transporting youth, service management activities, and other administrative functions shall be allowable indirect costs subject to the restrictions set forth in rule 441—150.3(234).

d. When youth receive services in a group rather than individually, the purchase of service contract shall specify the unit rate for group services separate from other services defined in the contract.

(1) The unit of service for group services shall be based on one hour, or any quarter portion thereof, of direct face-to-face contact between the service provider and each group member. Monthly cumulative units shall be rounded up or down to the nearest whole unit. The contract shall specify the average number of group participants.

(2) The unit rate shall be based upon the cost of the service when provided by a single caseworker. Reimbursement for a team approach to service delivery will not be made except in accordance with subparagraph (3) below.

(3) When two or more individuals from a service provider agency jointly deliver a unit of service, billings for that unit of service shall be reimbursable in an amount equal to the cost of two or more units of service if the following criteria are met:

1. The department case plan requests a team approach to service delivery and specifies the number of individuals that will be working together on the team, and a purchase of service contract identifies the service provider's ability to provide a team approach.

2. The specific number of individuals requested in the case plan who are representing the service provider are physically present to deliver the service to the youth.

202.9(5) Reserved.

202.9(6) *Termination of services.*

a. Mandatory termination. Supervised apartment living services shall be terminated when any of the following occurs:

(1) The youth no longer meets the definition of a child in Iowa Code section 234.1.

(2) The youth fails to meet the work (or work training) requirement for 30 consecutive days.

(3) The youth no longer needs foster care placement and services.

(4) The youth needs a more restrictive level of placement.

(5) The youth chooses to live in a nonapproved setting.

(6) The youth refuses to follow the provisions of the case plan, after having been given the opportunity to correct the behavior.

(7) to (10) Rescinded IAB 3/31/04, effective 6/1/04.

(11) The youth is aged 18 or over and fails to make satisfactory progress towards completion of the high school GED program, after having been given the opportunity to correct the behavior.

b. Notice of adverse action. When services are denied or terminated, adequate and timely notice shall be provided the youth as defined in rule 441—130.5(234).

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.10(234) Services to foster parents. Foster parents shall be provided necessary supportive services for the purpose of aiding them in the care and supervision of the child. These services shall include, but not be limited to:

202.10(1) Availability of social service staff on a 24-hour basis in case of emergency.

202.10(2) Conferences to develop in-depth planning regarding family visits, expectations of the department, future objectives and time frames, use of resources, and termination of placements.

202.10(3) Visitation by the service worker at least monthly regardless of the duration of the placements.

202.10(4) Making available all known pertinent information needed for the care of the child including HIV status, safety-related information, and special confidentiality requirements.

a. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information. The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

b. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. When continued breastfeeding of the child is determined to be in the best interest of the child, the service worker and the foster parents shall make reasonable efforts to support the continued breastfeeding of the child by the mother.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.11(234) Services to the child. The department service worker shall maintain a continuous relationship with the child.

202.11(1) The department service worker shall:

a. Help the child plan for the future,

b. Evaluate the child's needs and progress,

c. Supervise the living arrangement,

d. Arrange for social and other related services including, but not limited to, medical, psychiatric, psychological, and educational services from other resources as needed, and

e. Counsel the child in adjusting to the placement.

202.11(2) The assigned department service worker shall personally visit each child in out-of-home care at least once every calendar month, with the frequency of the vists based upon the needs of the child.

a. The visit shall take place in the child's place of residence the majority of the time.

b. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

202.11(3) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding for the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

202.11(4) When a child is in continuous foster care, a new physical examination shall not be required when the child transfers from one foster care placement to another unless there is some indication that an examination is necessary. The service worker shall obtain from the health practitioner or practitioners an annual medical review of treatment the child has received.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

202.11(5) Throughout the provision of care, the foster care provider shall actively ensure that the child stays connected to the child's kin, culture, and community as documented in the child's case permanency plan.

202.11(6) When the child has reached the age of majority under state law, the department shall provide a free copy of the child's health and education records to the child when the child leaves foster care.

202.11(7) Independent living program. The purpose of the independent living program is to provide supports and services that assist children currently or formerly in foster care in acquiring skills and abilities necessary for successful adult living. The independent living program offers a life skills assessment, transition plan development, and transition services.

a. Eligibility. To be eligible for the independent living program, a child must be under the age of 21, must be or have been in foster care as defined by rule 441—202.1(234) or 45 Code of Federal Regulations 1355.20 as amended to October 1, 2008, and must meet at least one of the following eligibility requirements:

(1) Is currently in foster care and is 16 years of age or older.

(2) Was adopted from foster care on or after October 7, 2008, and was at least 16 years of age at the time of adoption.

(3) Was placed in a subsidized guardianship arrangement from foster care on or after October 7, 2008, and was at least 16 years of age at the time of placement.

(4) Was formerly in foster care and is eligible for and participating in Iowa's aftercare services program as described at 441—Chapter 187.

b. Assessment. A life skills assessment shall be administered to all children in foster care who are aged 16 or older. An assessment shall be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a."* The assessment is designed to evaluate the child's strengths and needs in areas including, but not limited to:

(1) Education,

(2) Physical and mental health,

(3) Employment,

(4) Housing and money management, and

(5) Supportive relationships.

c. Transition plan development. A transition plan shall be completed for all children in foster care who are aged 16 or older, as provided in Iowa Code section 232.2(4)*"f."* Transition plan development shall also be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a,"* but the transition plan will not be part of a case permanency plan.

(1) The transition plan shall be personalized at the direction of the child and shall be developed and reviewed by the department in collaboration with a child-centered transition team, honoring the goals and concerns of the child.

(2) The transition plan shall address the strengths and needs identified in the assessment; detail the steps, services, supports and referrals needed to implement the plan to best assist the child in preparing for adulthood; and document the membership of the transition team and the meeting dates for the team.

(3) The transition plan shall be reviewed and updated at each case review after the plan's initial development; within 90 days before the child's eighteenth birthday; and within 90 days before the child is expected to leave foster care if the child remains in care after reaching the age of 18.

d. Transition services. Children shall be offered services, supports, and referrals within some or all of the five areas described below according to the child's strengths and needs as documented by the transition plan.

(1) Education skills increase the child's chances of completing high school or obtaining a GED and of entering a satisfying career. Services may include assistance in academic advising and guidance, secondary and postsecondary educational support, records transfer coordination, tutoring, financial aid planning, career exploration, mentoring, and career advising. Education financial assistance may be available to eligible children.

(2) Physical and mental health skills promote healthy physical, mental and emotional functioning. Health education services may include guidance on risk prevention, how to be healthy and fit, how to

self-advocate for health care needs, how to select medical professionals, and how to make informed decisions regarding treatment, lifestyle considerations, spirituality, and recreation.

(3) Employment skills enable children to prepare for, seek, and maintain gainful career employment. Services may include employment programs or vocational training, employment search resources, career advising, résumé writing, interview skills, workplace etiquette, and on-the-job training.

(4) Housing and money management skills prepare a child to select, manage, and maintain safe and stable housing. Services may include lessons on the physical maintenance and cleaning of a house and guidance on managing personal finances, such as financial decisions, budgeting, bill paying, use of credit, and financing. Financial assistance for room and board may be available to children who meet the eligibility criteria of the preparation for adult living program pursuant to 441—Chapter 187.

(5) Supportive relationships skills promote the healthy development and maintenance of rewarding, lasting relationships. Services may include family support and healthy marriage education, mentoring opportunities, and guidance on how to recognize the needs of others, how to identify and understand personal motivations, how to ensure personal safety, and how to communicate effectively.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8718B**, IAB 5/5/10, effective 7/1/10]

441—202.12(234) Services to parents.

202.12(1) Child welfare services shall be made available to the parents throughout the period of placement for the purpose of reuniting the family in an agreed-upon time frame. Family safety, risk, and permanency services may be provided to:

a. Promote identification and enhancement of family strengths and protective capacities;

b. Address the factors that resulted in the child's being removed from the family home; and

c. Strengthen family connections to community resources and informal supports.

202.12(2) The parents shall be notified of the location and nature of the child's placement, unless it is documented in the child's case record that to do so would be disruptive to the placement.

202.12(3) The case plan and treatment plan shall specify the services to be provided and the time frame for reuniting the family. These plans shall be developed in cooperation with the parents.

202.12(4) Personal contact shall be made regularly with the parents and the progress towards goal attainment reviewed and documented in the case record. The frequency of the personal contact shall be at least monthly and shall be specified in the child's case permanency plan.

202.12(5) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding of the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.13(234) Removal of the child.

202.13(1) When the department plans to remove a child from a facility, the facility shall be informed in writing of the date of the removal, the reason for the removal, the recourse available to the facility, if any, and that the chapter 17A contested case proceeding is not applicable to the removal. The department shall inform the facility ten days in advance of the removal, except that the facility may be informed less than ten days prior to the removal in the following instances:

a. When the parent or guardian removes the child from voluntary placement.

b. When the court orders removal of a child from placement.

c. When there is evidence of neglect or physical or sexual abuse.

202.13(2) The department may remove a child from a facility when any of the following conditions exist:

a. There is evidence of abuse, neglect, or exploitation of the child.

b. The child needs a specialized service that the facility does not offer.

c. The child is unable to benefit from the placement as evidenced by lack of progress of the child.

d. There is evidence the facility is unable to provide the care needed by the child and fulfill its responsibilities under the case plan.

e. There is lack of cooperation of the facility with the department.

202.13(3) If a foster family objects in writing within seven days from the date that the department furnishes notice of plans to remove the child, the service area manager or designee shall grant a conference to the foster family to determine whether the removal is in the child's best interest.

a. This conference shall not be construed to be a contested case under the Iowa administrative procedure Act, Iowa Code chapter 17A.

b. The conference shall be provided before the child is removed except in instances listed in 202.13(1)*"a"* to *"c."* The service area manager or designee shall review the propriety of the removal and explain the decision to the foster family.

c. The service area manager or designee, on finding that the removal is not in the child's best interests, may overrule the removal decision unless a court order or parental decision prevents the department from doing so.

202.13(4) When the facility requests a child be removed from its care, it shall give a minimum of ten days' notice to the department so planning may be made on behalf of the child.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.14(234) Termination. The foster care services shall be terminated when the child is no longer an eligible child, or when the attainment of goals in the case plan has been achieved, or when the goals for whatever reasons cannot be achieved, or when it is evident that the family or individual is unable to benefit from the service or unwilling to accept further services.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.15(234) Case permanency plan.

202.15(1) The department worker shall ensure that a case permanency plan is developed for each child who is placed in foster care if the department has agreed to provide foster care through a voluntary placement agreement, if a court has transferred custody or guardianship to the department for the purpose of foster care, or if a court has placed the child in foster care and ordered the department to supervise the placement.

202.15(2) The department worker shall develop the case permanency plan with the child's parents, unless the child's parents are unwilling to participate in the plan's development, and with the child, unless the child is unable or unwilling to participate.

202.15(3) The department worker shall be responsible for ensuring the development of the case permanency plan within the time frames specified in rule 441—130.7(234). In all cases, the case permanency plan shall be completed within 60 days of the date the child entered foster care.

202.15(4) Copies of the initial and subsequent case permanency plans shall be provided to the child, the child's parents, and the foster care provider. Copies shall also be provided to the following, if involved in services to the child: the juvenile court officer, the judge, the child's attorney, the child's guardian ad litem, the child's guardian, the child's custodian, the child's court-appointed special advocate, the parents' attorneys, the county attorney, the state foster care review board, and any other interested parties identified in the plan.

202.15(5) The initial and subsequent case permanency plans shall be completed on the forms specified in rule 441—130.7(234).

202.15(6) Rescinded IAB 4/28/04, effective 6/2/04.

441—202.16(135H) Department approval of need for a psychiatric medical institution for children.

202.16(1) Applicants for departmental approval of need shall submit the following to the division of child and family services:

a. A description of the population to be served, including age, sex, and types of disorders, and an estimate of the number of these youth in need of psychiatric care in the area of the state in which the applicant is located.

b. A statement of the number of beds requested and a description of the treatment program to be provided, the outcomes to be achieved and the techniques for measuring outcomes.

c. A proposed date of operation as a psychiatric medical institution for children.

d. A description of the applicant's experience with providing similar services to youth, especially the target population.

e. A description of the applicant's plan, including the timeline for achieving accreditation to provide psychiatric services from a federally recognized accrediting organization under the organization's standards for residential settings and licensure as a psychiatric medical institution for children, or a copy of the organization's report if already accredited.

f. References from the service area manager for the department service area in which the proposed psychiatric medical institution for children would be located, the chief juvenile court officer of the judicial district in which the proposed psychiatric medical institution for children would be located and the applicant's licensor from the department of inspections and appeals or department of public health.

202.16(2) The department shall evaluate proposals and issue a decision based on the following criteria:

a. The number of psychiatric medical institutions for children beds for the proposed population which are needed in the area of the state in which the facility would be located, based on the department's most recent needs assessment.

b. The steps the facility has taken towards achieving accreditation from a federally recognized accrediting organization and licensure as a psychiatric medical institution for children.

c. The applicant's ability to provide services and support consistent with the requirements under Iowa Code chapter 232 including, but not limited to, evidence that:

(1) Children will be served in a setting which is in close proximity to their parents' home.

(2) Each child will receive services consistent with the child's best interests and special psychiatric needs as identified in the child's case permanency plan.

(3) Children and their families will receive services to facilitate the children's return home or other permanent placement.

d. The applicant's ability to provide children with a non-hospital-type living environment if the applicant is not freestanding from a hospital or health care facility.

e. The limits on the number of beds found in Iowa Code section 135H.6, subsection 5.

202.16(3) If a facility has not been licensed as a psychiatric medical institution for children within one year after the date of the department's approval of need, the department's approval shall expire unless the department has approved an extension. An extension may be approved up to a maximum of six months if the agency has documented extenuating circumstances which prevented completion of the licensing process.

This rule is intended to implement Iowa Code section 135H.6.

441—202.17(232) Area group care targets.

202.17(1) *Area target.* A group care budget target shall be established for each departmental service area, which shall be based on the annual statewide group care appropriation established by the general assembly.

a. The department and the judicial branch shall jointly develop a formula for allocating the group care appropriation among the departmental service areas. The formula shall be based on:

(1) Proportional child population.

(2) Proportional group foster care usage in the previous five completed fiscal years.

(3) Other indicators of need.

b. Any portion of the group care appropriation allocated for 50 highly structured juvenile program beds and not used may be used for group care.

c. Upon written agreement of the affected service area managers and chief juvenile court officers, service areas may transfer part of their group care budget from one service area to another. A service area may exceed its budget target figure up to 5 percent during the fiscal year, providing that the overall funding allocation by the department for all child welfare services in the service area is not exceeded.

d. Notwithstanding the statewide appropriation established in this subrule, a budget established in a service area's group care plan pursuant to Iowa Code section 232.143 may be exceeded, a group care placement may be ordered, and state payment may be made if the review organization finds that the placement is necessary to meet the child's service needs and if the service area has additional funds transferred from another service area or if the service area is within 5 percent of its group care budget target figure pursuant to 441—paragraph 202.17(1)*"c."*

The department and juvenile court services shall work together to ensure that a service area's group care expenditures shall not exceed the funds allocated to the service area for group care in the fiscal year.

e. If at any time after September 30, 1998, annualization of a service area's current expenditures indicates a service area is at risk of exceeding its group foster care expenditure target under Iowa Code section 232.143 by more than 5 percent, the department and juvenile court services shall examine all group foster care placements in that service area in order to identify those which might be appropriate for termination. In addition, any aftercare services believed to be needed for the children whose placements may be terminated shall be identified.

The department and juvenile court services shall initiate action to set dispositional review hearings for the placements identified. In the dispositional review hearing, the juvenile court shall determine whether needed aftercare services are available and whether termination of the placement is in the best interest of the child and the community.

202.17(2) *Plan for achieving target.* For each of the departmental service areas, representatives appointed by the department and juvenile court services shall establish a plan for containing the expenditure for children placed in group care within the budget target allocated to that service area. The plan shall include monthly targets and strategies for developing alternatives to group care placements.

The plans shall also ensure potential group care referrals are reviewed by the review organization prior to submission of a recommendation for group care placement to the court.

Each area plan shall be established in advance of the fiscal year to which the plan applies. To the extent possible, the department and the juvenile court shall coordinate the planning required under this subrule with planning for services paid under Iowa Code section 232.141, subsection 4. The department's service area manager shall communicate regularly, as specified in the area plan, with the juvenile courts within the service area concerning the current status of the plan's implementation.

This rule is intended to implement Iowa Code section 232.143.

441—202.18(235) Local transition committees. Local transition committees shall be established in each of the department service areas. The service area manager or designee shall determine the number of local transition committees needed within the service area, set operating policies and procedures, and appoint committee membership.

202.18(1) *Purpose.* The purpose of local transition committees, as established by Iowa Code Supplement section 235.7, is to ensure that the transition needs of youth in foster care who are 16 years of age or older have been addressed in order to assist the youth in preparing for the transition from foster care to adulthood.

202.18(2) *Membership.* Each committee shall have a designated number of members.

a. The standing committee membership may include, but is not limited to:

(1) Department staff involved with child welfare, adult services, or transition planning.
(2) Juvenile court services staff.
(3) Adult service system staff.
(4) Education staff.
(5) Service care provider representation.
(6) Others knowledgeable about community resources.

b. Additionally, nonstanding membership may include those knowledgeable about the youth, including the child's court-appointed special advocate, guardian ad litem, and service or care providers.

c. In areas where teams or boards already in existence are involved in review and planning for youth needs, such as the foster care review board or child welfare funding decategorization boards, such teams or boards may serve as local transition committees.

202.18(3) *Duties.* Local transition committees shall address the transition needs of youth in foster care who are 16 years of age or older and who have a case permanency plan as defined in Iowa Code Supplement section 232.2. Each committee shall have operating policies and procedures to carry out the duties below.

a. Each committee shall establish a process for review and approval of written transition plans for youth for whom the committee has placement responsibility that meets a continuum of case needs and coordinates with local transition planning protocol. The process may include a paper review or an in-person review, or both, according to case need.

b. The committee may be involved when the youth is at least 16 years of age, but shall be involved in reviewing and approving a youth's transition plan before the youth reaches age 17½. When a youth enters foster care at age 17½ or older, the committee shall be involved in reviewing and approving the youth's transition plan within 30 days of completion.

c. In reviewing a youth's transition plan, the committee shall identify and act to address gaps existing in services or supports available that would assist the youth in the transition from foster care to adulthood.

d. For those youth expected to need services as adults, the committee shall ensure that the transition plan was developed with the participation of any person reasonably expected to be a service provider when the youth becomes an adult or to become responsible for the costs of services at that time.

e. The committee shall ensure that transition planning and review is coordinated with overall case planning and review. Committee review and approval shall be indicated in the youth's case permanency plan.

f. With respect to meetings involving a specific youth receiving foster care and the youth's family, the local transition committees are not subject to Iowa Code chapter 21.

g. The information and records of or provided to a local transition committee regarding a youth receiving foster care and the youth's family are not public records pursuant to Iowa Code chapter 22 when the records relate to the foster care placement and transition needs of the youth.

h. Members of the committees are subject to the standards of confidentiality set forth in Iowa Code sections 600.16, 217.30 and 235A.15.

202.18(4) *Report.* The service area manager or designee shall submit a report on transition planning committees to the department's division of child and family services. The report shall be submitted annually by October 1 for the immediately preceding fiscal year. The report shall include, but not be limited to, the following:

a. The geographical area covered for each committee within the service area.

b. Standing committee membership for each committee.

c. The number of cases reviewed by each committee.

d. Identification of barriers to successful transition and gaps in community services or supports.

e. Suggestions for ways to transition youth from foster care to adulthood more effectively.

This rule is intended to implement Iowa Code Supplement section 235.7.

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CHAPTER 135
TECHNICAL STANDARDS AND CORRECTIVE ACTION REQUIREMENTS FOR OWNERS AND OPERATORS OF UNDERGROUND STORAGE TANKS

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—135.1(455B) Authority, purpose and applicability.

135.1(1) *Authority.* Iowa Code chapter 455B, division IV, part 8, authorizes the department to regulate underground tanks used for storage of regulated substances, and to adopt rules relating to detection, prevention and correction of releases of regulated substances from such tanks, maintenance of financial responsibility by owners or operators of such tanks, new tank performance standards, notice and reporting requirements, and designation of regulated substances.

135.1(2) *Purpose.* The purpose of these rules is to protect the public health and safety and the natural resources of Iowa by timely and appropriate detection, prevention and correction of releases of regulated substances from underground storage tanks (UST).

135.1(3) *Applicability.*

a. The requirements of this chapter apply to all owners and operators of a UST system as defined in 135.2(455B) except as otherwise provided in paragraphs *"b," "c,"* and *"d"* of this subrule. Any UST system listed in paragraph *"c"* of this subrule must meet the requirements of 135.1(4).

b. The following UST systems are excluded from the requirements of this chapter:

(1) Any UST system holding hazardous wastes listed or identified under Subtitle C of the Solid Waste Disposal Act, or a mixture of such hazardous waste and other regulated substances.

(2) Any wastewater treatment tank system that is part of a wastewater treatment facility regulated under Section 402 or 307(b) of the federal Clean Water Act.

(3) Equipment or machinery that contains regulated substances for operational purposes such as hydraulic lift tanks and electrical equipment tanks.

(4) Any UST system whose capacity is 110 gallons or less.

(5) Any UST system that contains a de minimus concentration of regulated substances.

(6) Any emergency spill or overflow containment UST system that is expeditiously emptied after use.

c. Deferrals. Rules 135.3(455B), 135.4(455B), 135.5(455B), 135.6(455B) and 135.9(455B) do not apply to any of the following types of UST systems:

(1) Wastewater treatment tank systems;

(2) Any UST systems containing radioactive material that are regulated under the federal Atomic Energy Act of 1954 (42 U.S.C. 2011 and following);

(3) Any UST system that is part of an emergency generator system at nuclear power generation facilities regulated by the Nuclear Regulatory Commission under 10 CFR 50 Appendix A;

(4) Airport hydrant fuel distribution systems; and

(5) UST systems with field-constructed tanks.

d. Deferrals. Rule 135.5(455B) does not apply to any UST system that stores fuel solely for use by emergency power generators. All new and replacement UST systems for emergency power generators must meet the secondary containment requirements in subrule 135.3(9) and the leak detection and delivery prohibition requirements in subrule 135.3(8).

e. Nonpetroleum underground storage tank systems. Rules 135.8(455B) to 135.12(455B) do not apply to any nonpetroleum underground storage tank system except as otherwise provided for by the department.

135.1(4) *Interim prohibition for deferred UST systems.*

a. No person may install a UST system listed in 135.1(3)*"c"* for the purpose of storing regulated substances unless the UST system (whether of single- or double-wall construction):

(1) Will prevent releases due to corrosion or structural failure for the operational life of the UST system;

(2) Is cathodically protected against corrosion, constructed of noncorrodible material, steel clad with a noncorrodible material, or designed in a manner to prevent the release or threatened release of any stored substance; and

(3) Is constructed or lined with material that is compatible with the stored substance.

b. Notwithstanding paragraph *"a"* of this subrule, a UST system without corrosion protection may be installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life. Owners and operators must maintain records that demonstrate compliance with the requirements of this paragraph for the remaining life of the tank.

NOTE: The National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," may be used as guidance for complying with 135.1(4)*"b."*

567—135.2(455B) Definitions.

"Aboveground release" means any release to the surface of the land or to surface water. This includes, but is not limited to, releases from the aboveground portion of a UST system and aboveground releases associated with overfills and transfer operations as the regulated substance moves to or from a UST system.

"Active remediation" means corrective action undertaken to reduce contaminant concentrations by other than passive remediation or monitoring.

"Ancillary equipment" means any devices including, but not limited to, such devices as piping, fittings, flanges, valves, and pumps used to distribute, meter, or control the flow of regulated substances to and from a UST.

"Appurtenances" means devices such as piping, fittings, flanges, valves, dispensers and pumps used to distribute, meter, or control the flow of regulated substances to or from an underground storage tank.

"ASTM" means the American Society of Testing and Materials.

"Bedrock" means the rock, usually solid, underlying soil or any other unconsolidated surficial cover.

"Below-ground release" means any release to the subsurface of the land and to groundwater. This includes, but is not limited to, releases from the below-ground portions of an underground storage tank system and below-ground releases associated with overfills and transfer operations as the regulated substance moves to or from an underground storage tank.

"Beneath the surface of the ground" means beneath the ground surface or otherwise covered with earthen materials.

"Best available technology" means those practices which most appropriately remove, treat, or isolate contaminants from groundwater, soil or associated environment, as determined through professional judgment considering actual equipment or techniques currently in use, published technical articles, site hydrogeology and research results, engineering and groundwater professional reference materials, consultation with experts in the field, capital and operating costs, and guidelines or rules of other regulatory agencies.

"Best management practices" means maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, is determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil.

"Carcinogenic risk" means the incremental risk of a person developing cancer over a lifetime as a result of exposure to a chemical, expressed as a probability such as one in a million (10^{-6}). For carcinogenic chemicals of concern, probability is derived from application of certain designated exposure assumptions and a slope factor.

"Cathodic protection" is a technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell. For example, a tank system can be cathodically protected through the application of either galvanic anodes or impressed current.

"Cathodic protection tester" means a person who can demonstrate an understanding of the principles and measurements of all common types of cathodic protection systems as applied to buried or submerged metal piping and tank systems. At a minimum, such persons must have education and experience in soil

resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements of buried metal piping and tank systems.

"CERCLA" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

"Certified groundwater professional" means a person certified pursuant to 1995 Iowa Code section 455G.18 and 567—Chapter 134.

"Change-in-service" means changing the use of a tank system from a regulated to a nonregulated use.

"Chemicals of concern" means the compounds derived from petroleum-regulated substances which are subject to evaluation for purposes of applying risk-based corrective action decision making. These compounds are benzene, ethylbenzene, toluene, and xylenes (BTEX) and naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. (NOTE: Measurement of these last four constituents may be done by a conversion method from total extractable hydrocarbons, see subrule 135.8(3).)

"Class A operator" means a person responsible for managing resources and personnel to achieve and maintain compliance with regulatory requirements under this chapter. This includes ensuring appropriate individuals are trained in the proper operation and maintenance of the underground storage tank system, the maintenance of all required records, the procedures for response to emergencies caused by releases or spills, and assuring financial responsibility and documentation to the department or its representatives as required.

"Class B operator" means a person who implements applicable underground storage tank regulatory requirements and standards. This includes implementing the day-to-day aspects of operating, maintaining, and record keeping for underground storage tanks at one or more facilities. A Class B operator typically monitors, maintains and ensures that release detection methods, record-keeping, and reporting requirements are met; release prevention equipment, record-keeping, and reporting requirements are met; all relevant equipment complies with performance standards; and appropriate individuals are trained to properly respond to emergencies caused by releases and spills.

"Class C operator" means an on-site employee who typically controls or monitors the dispensing or sale of regulated substances and who is the first line of response to events indicating emergency conditions.

"Compatible" means the ability of two or more substances to maintain their respective physical and chemical properties upon contact with one another for the design life of the tank system under conditions likely to be encountered in the UST.

"Conduit" means underground structures which act as pathways and receptors for chemicals of concern, including but not limited to gravity drain lines and sanitary or storm sewers.

"Connected piping" means all underground piping including valves, elbows, joints, flanges, and flexible connectors attached to a tank system through which regulated substances flow. For the purpose of determining how much piping is connected to any individual UST system, the piping that joins two UST systems should be allocated equally between them.

"Consumptive use" with respect to heating oil means consumed on the premises.

"Corrective action" means an action taken to reduce, minimize, eliminate, clean up, control or monitor a release to protect the public health and safety or the environment. Corrective action includes, but is not limited to, excavation of an underground storage tank for the purpose of repairing a leak or removal of a tank, removal of contaminated soil, disposal or processing of contaminated soil, cleansing of groundwaters or surface waters, natural biodegradation, institutional controls, technological controls and site management practices. Corrective action does not include replacement of an underground storage tank. Corrective action specifically excludes third-party liability.

"Corrective action meeting process" means a series of meetings organized by department staff with owners or operators and other interested parties such as certified groundwater professionals, funding source representatives, and affected property owners. The purpose of the meeting process is to develop and agree on a corrective action plan and the terms for implementation of the plan.

"Corrective action plan" means a plan which specifies the corrective action to be undertaken by the owner or operator in order to comply with requirements in this chapter and which is incorporated

into a memorandum of agreement or other written agreement between the department and the owner or operator. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

"Corrosion expert" means a person who, by reason of thorough knowledge of the physical sciences and the principles of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person must be accredited or certified as being qualified by the National Association of Corrosion Engineers or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control of buried or submerged metal piping systems and metal tanks.

"Department" means Iowa department of natural resources.

"Dielectric material" means a material that does not conduct direct electrical current. Dielectric coatings are used to electrically isolate UST systems from the surrounding soils. Dielectric bushings are used to electrically isolate portions of the UST systems (e.g., tank from piping).

"Dispenser" means equipment that is used to transfer a regulated substance from underground piping through a rigid or flexible hose or piping located aboveground to a point of use outside the underground storage tank system, such as a motor vehicle.

"Drinking water well" means any groundwater well used as a source for drinking water by humans and groundwater wells used primarily for the final production of food or medicine for human consumption in facilities routinely characterized with the Standard Industrial Codes (SIC) group 283 for drugs and 20 for foods.

"Electrical equipment" means underground equipment that contains dielectric fluid that is necessary for the operation of equipment such as transformers and buried electrical cable.

"Enclosed space" means space which can act as a receptor or pathway capable of creating a risk of explosion or inhalation hazard to humans and includes "explosive receptors" and "confined spaces." Explosive receptors means those receptors designated in these rules which are evaluated for explosive risk. Confined spaces means those receptors designated in these rules for evaluation of vapor inhalation risks.

"Excavation zone" means the volume containing the tank system and backfill material bounded by the ground surface, walls, and floor of the pit and trenches into which the UST system is placed at the time of installation.

"Existing tank system" means a tank system used to contain an accumulation of regulated substances or for which installation has commenced on or before January 14, 1987. Installation is considered to have commenced if:

The owner or operator has obtained all federal, state, and local approvals or permits necessary to begin physical construction of the site or installation of the tank system; and if,

1. Either a continuous on-site physical construction or installation program has begun; or,
2. The owner or operator has entered into contractual obligations, which cannot be canceled or modified without substantial loss, for physical construction at the site or installation of the tank system to be completed within a reasonable time.

"Farm tank" is a tank located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. "Farm" includes fish hatcheries, rangeland and nurseries with growing operations.

"Flow-through process tank" is a tank that forms an integral part of a production process through which there is a steady, variable, recurring, or intermittent flow of materials during the operation of the process. Flow-through process tanks do not include tanks used for the storage of materials prior to their introduction into the production process or for the storage of finished products or by-products from the production process.

"Free product" refers to a regulated substance that is present as a nonaqueous phase liquid (e.g., liquid not dissolved in water).

"Gathering lines" means any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

"Groundwater ingestion pathway" means a pathway through groundwater by which chemicals of concern may result in exposure to a human receptor as specified in rules applicable to Tier 1, Tier 2 and Tier 3.

"Groundwater plume" means the extent of groundwater impacted by the release of chemicals of concern.

"Groundwater to plastic water line pathway" means a pathway through groundwater which leads to a plastic water line.

"Groundwater vapor to enclosed space pathway" means a pathway through groundwater by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

"Hazardous substance UST system" means an underground storage tank system that contains a hazardous substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (but not including any substance regulated as a hazardous waste under subtitle C) or any mixture of such substances and petroleum, and which is not a petroleum UST system.

"Hazard quotient" means the ratio of the level of exposure of a chemical of concern over a specified time period to a reference dose for that chemical of concern derived for a similar exposure period. Unless otherwise specified, the hazard quotient designated in these rules is one.

"Heating oil" means petroleum that is No. 1, No. 2, No. 4-light, No. 4-heavy, No. 5-light, No. 5-heavy, and No. 6 technical grades of fuel oil; other residual fuel oils (including Navy Special Fuel Oil and Bunker C); and other fuels when used as substitutes for one of these fuel oils. Heating oil is typically used in the operation of heating equipment, boilers, or furnaces.

"Highly permeable soils" means for the purpose of UST closures: fractured bedrock, any soils with a hydraulic conductivity rate greater than 0.3 meters per day, or any soil material classified by the Unified Soil Classification System as published by the United States Department of the Interior or ASTM designation as (1) GW - well graded gravel, gravel-sand mixtures, little or no fines, (2) GP - poorly graded gravel, gravel-sand mixtures, little or no fines, (3) SW - well graded sands, gravelly sands, little or no fines, or (4) SP - poorly graded sands, gravelly sands, little or no fines.

"Hydraulic conductivity" means the rate of water movement through the soil measured in meters per day (m/d) as determined by the following methods. For a saturated soil, the Bouwer-Rice method or its equivalent shall be used. For unsaturated soil, use a Guelph permeameter or an equivalent in situ constant-head permeameter in a boring finished above the water table. If an in situ method cannot be used for unsaturated soil because of depth, or if the soil is homogeneous and lacks flow-conducting channels, fractures, cavities, etc., laboratory measurement of hydraulic conductivity is acceptable.

If laboratory methods are used, collect undisturbed soil samples using a thin-walled tube sampler in accordance with American Society of Testing and Materials (ASTM) Standard D1587. Samples shall be clearly marked, preserved and transported to the laboratory. The laboratory shall measure hydraulic conductivity using a constant-head permeameter in accordance with ASTM Standard D2434 or a falling-head permeameter in accordance with accepted methodology.

"Hydraulic lift tank" means a tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air or hydraulic fluid to operate lifts, elevators, and other similar devices.

"Institutional controls" means the restriction on use or access (for example, fences, deed restrictions, restrictive zoning) to a site or facility to eliminate or minimize potential exposure to a chemical(s) of concern. Institutional controls include any of the following:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. A restriction on the use of or activities occurring at real estate which are embodied in a covenant running with the land which:

- Contains a legal description of the real estate in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is properly executed, in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is recorded in the appropriate office of the county in which the real estate is located;
- Adequately and accurately describes the institutional control; and
- Is in the form of a covenant as set out in Appendix C or in such a manner reasonably acceptable to the department.

5. Any other institutional control the owner or operator can reasonably demonstrate to the department which will reduce the risk from a release throughout the period necessary to ensure that no applicable target risk is likely to be exceeded.

"Liquid trap" means sumps, well cellars, and other traps used in association with oil and gas production, gathering, and extraction operations (including gas production plants), for the purpose of collecting oil, water, and other liquids. These liquid traps may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

"Maintenance" means the normal operational upkeep to prevent an underground storage tank system from releasing product.

"MCLs" means the drinking water primary maximum contaminant levels set out in 567—41.3(455B).

"Memorandum of agreement" means a written agreement between the department and the owner or operator which specifies the corrective action that will be undertaken by the owner or operator in order to comply with requirements in this chapter and the terms for implementation of the plan. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

"Motor fuel" means petroleum or a petroleum-based substance that is motor gasoline, aviation gasoline, No. 1 or No. 2 diesel fuel, or any grade of gasohol, and is typically used in the operation of a motor engine.

"New tank system" means a tank system that will be used to contain an accumulation of regulated substances and for which installation has commenced after January 14, 1987. (See also "Existing Tank System.")

"Noncarcinogenic risk" means the potential for adverse systemic or toxic effects caused by exposure to noncarcinogenic chemicals of concern, expressed as the hazard quotient.

"Noncommercial purposes" with respect to motor fuel means not for resale.

"Non-drinking water well" means any groundwater well (except an extraction well used as part of a remediation system) not defined as a drinking water well including a groundwater well which is not properly plugged in accordance with department rules in 567—Chapters 39 and 49.

"Nonresidential area" means land which is not currently used as a residential area and which is zoned for nonresidential uses.

"On the premises where stored" with respect to heating oil means UST systems located on the same property where the stored heating oil is used.

"Operational life" refers to the period beginning when installation of the tank system has commenced until the time the tank system is properly closed under rule 135.15(455B).

"Operator" means any person in control of, or having responsibility for, the daily operation of the UST system.

"Overfill release" is a release that occurs when a tank is filled beyond its capacity, resulting in a discharge of the regulated substance to the environment.

"Owner" means:

1. In the case of a UST system in use on July 1, 1985, or brought into use after that date, any person who owns a UST system used for storage, use, or dispensing of regulated substances; and

2. In the case of any UST system in use before July 1, 1985, but no longer in use on that date, any person who owned such UST immediately before the discontinuation of its use.

"Owner" does not include a person, who, without participating in the management or operation of the underground storage tank or the tank site, holds indicia of ownership primarily to protect that person's security interest in the underground storage tank or the tank site property, prior to obtaining ownership or control through debt enforcement, debt settlement, or otherwise.

"Pathway" means a transport mechanism by which chemicals of concern may reach a receptor(s) or the location(s) of a potential receptor.

"Permanent closure" means removing all regulated substances from the tank system, assessing the site for contamination, and permanently removing tank and piping from the ground or filling the tank in place with a solid inert material and plugging all piping. Permanent closure also includes partial closure of a tank system such as removal or replacement of tanks or piping only.

"Person" means an individual, trust, firm, joint stock company, federal agency, corporation, state, municipality, commission, political subdivision of a state, or any interstate body. "Person" also includes a consortium, a joint venture, a commercial entity, and the United States government.

"Person who conveys or deposits a regulated substance" means a person who sells or supplies the owner or operator with the regulated substance and the person who transports or actually deposits the regulated substance in the underground tank.

"Petroleum UST system" means an underground storage tank system that contains petroleum or a mixture of petroleum with de minimus quantities of other regulated substances. Such systems include those containing motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

"Pipe" or *"piping"* means a hollow cylinder or tubular conduit that is constructed of nonearthen materials and that routinely contains and conveys regulated substances from the underground tank(s) to the dispenser(s) or other end-use equipment. Such piping includes any elbows, couplings, unions, valves, or other in-line fixtures that contain and convey regulated substances from the underground tank(s) to the dispenser(s). This definition does not include vent, vapor recovery, or fill lines.

"Pipeline facilities (including gathering lines)" are new and existing pipe rights-of-way and any associated equipment, facilities, or buildings.

"Point of compliance" means the location(s) at the source(s) of contamination or at the location(s) between the source(s) and the point(s) of exposure where concentrations of chemicals of concern must meet applicable risk-based screening levels at Tier 1 or other target level(s) at Tier 2 or Tier 3.

"Point of exposure" means the location(s) at which an actual or potential receptor may be exposed to chemicals of concern via a pathway.

"Potential receptor" means a receptor not in existence at the time a Tier 1, Tier 2 or Tier 3 site assessment is prepared, but which could reasonably be expected to exist within 20 years of the preparation of the Tier 1, Tier 2 or Tier 3 site assessment or as otherwise specified in these rules.

"Preferential pathway" means conditions which act as a pathway permitting contamination to migrate through soils and to groundwater at a faster rate than would be expected through naturally occurring undisturbed soils or unfractured bedrock including but not limited to wells, cisterns, tile lines, drainage systems, utility lines and envelopes, and conduits.

"Protected groundwater source" means a saturated bed, formation, or group of formations which has a hydraulic conductivity of at least 0.44 meters per day (m/d) and a total dissolved solids of less than 2,500 milligrams per liter (mg/l) or a bedrock aquifer with total dissolved solids of less than 2,500 milligrams per liter (mg/l) if bedrock is encountered before groundwater.

"Public water supply well" means a well connected to a system for the provision to the public of piped water for human consumption, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

"Receptor" means enclosed spaces, conduits, protected groundwater sources, drinking and non-drinking water wells, surface water bodies, and public water systems which when impacted by chemicals of concern may result in exposure to humans and aquatic life, explosive conditions or other adverse effects on health, safety and the environment as specified in these rules.

"Reference dose" means a designated toxicity value established in these rules for evaluating potential noncarcinogenic effects in humans resulting from exposure to a chemical(s) of concern. Reference doses are designated in Appendix A.

"Regulated substance" means an element, compound, mixture, solution or substance which, when released into the environment, may present substantial danger to the public health or welfare or the environment. Regulated substance includes:

1. Substances designated in Table 302.4 of 40 CFR Part 302 (September 13, 1988),
2. Substances which exhibit the characteristics identified in 40 CFR 261.20 through 261.24 (May 10, 1984) and which are not excluded from regulation as a hazardous waste under 40 CFR 261.4(b) (May 10, 1984),
3. Any substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) of 1980 (but not including any substance regulated as a hazardous waste under subtitle C), and
4. Petroleum, including crude oil or any fraction thereof that is liquid at standard conditions of temperature and pressure (60 degrees Fahrenheit and 14.7 pounds per square inch absolute). The term "regulated substance" includes but is not limited to petroleum and petroleum-based substances comprised of a complex blend of hydrocarbons derived from crude oil through processes of separation, conversion, upgrading, and finishing, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

"Release" means any spilling, leaking, emitting, discharging, escaping, leaching or disposing of a regulated substance, including petroleum, from a UST into groundwater, surface water or subsurface soils.

"Release detection" means determining whether a release of a regulated substance has occurred from the UST system into the environment or into the interstitial space between the UST system and its secondary barrier or secondary containment around it.

"Repair" means to restore a tank or UST system component that has caused a release of product from the UST system.

"Replace" or *"replacement"* means the installation of a new underground tank system or component, including dispensers, in substantially the same location as an existing tank system or component in lieu of that tank system or component.

"Residential area" means land used as a permanent residence or domicile, such as a house, apartment, nursing home, school, child care facility or prison, land zoned for such uses, or land where no zoning is in place.

"Residential tank" is a tank located on property used primarily for dwelling purposes.

"Risk-based screening level (RBSL)" means the risk-based concentration level for chemicals of concern developed for a Tier 1 analysis to be met at the point(s) of compliance and incorporated in the Tier 1 Look-up Table in Appendix A.

"SARA" means the federal Superfund Amendments and Reauthorization Act of 1986.

"Secondary containment tank" or *"secondary containment piping"* means a tank or piping which is designed with an inner primary shell and a liquid-tight outer secondary shell or jacket which extends around the entire inner shell, and which is designed to contain any leak through the primary shell from any part of the tank or piping that routinely contains product, and which also allows for monitoring of the interstitial space between the shells and the detection of any leak.

"Septic tank" is a watertight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer. The effluent from such receptacle is distributed for disposal through the soil and settled solids and scum from the tank are pumped out periodically and hauled to a treatment facility.

"Site assessment investigation" means an investigation conducted by a registered groundwater professional to determine relevant site historical data, the types, amounts, and sources of petroleum contaminants present, hydrogeological characteristics of the site, full vertical and horizontal extent of the contamination in soils and groundwater, direction and rate of flow of the contamination, ranges of concentration of the contaminants by analysis of soils and groundwater, the vertical and horizontal

extent of the contamination exceeding department standards, and the actual or potential threat to public health and safety and the environment.

"Site cleanup report" means the report required to be submitted by these rules and in accordance with department guidance which may include the results of Tier 2 or Tier 3 assessment and analysis.

"Site-specific target level (SSTL)" means the risk-based target level(s) for chemicals of concern developed as the result of a Tier 2 or Tier 3 assessment which must be achieved at applicable point(s) of compliance at the source to meet the target level(s) at the point(s) of exposure.

"Soil leaching to groundwater pathway" means a pathway through soil by which chemicals of concern may leach to groundwater and through a groundwater transport pathway impact an actual or potential receptor.

"Soil plume" means the vertical and horizontal extent of soil impacted by the release of chemicals of concern.

"Soil to plastic water line pathway" means a pathway which leads from soil to a plastic water line.

"Soil vapor to enclosed space pathway" means a pathway through soil by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

"Storm water or wastewater collection system" means piping, pumps, conduits, and any other equipment necessary to collect and transport the flow of surface water run-off resulting from precipitation, or domestic, commercial, or industrial wastewater to and from retention areas or any areas where treatment is designated to occur. The collection of storm water and wastewater does not include treatment except where incidental to conveyance.

"Surface impoundment" is a natural topographic depression, constructed excavation, or diked area formed primarily of earthen materials (although it may be lined with manufactured materials) that is not an injection well.

"Surface water body" means general use segments as provided in 567—paragraph 61.3(1)*"a"* and designated use segments of water bodies as provided in 567—paragraph 61.3(1)*"b"* and 567—subrule 61.3(5).

"Surface water criteria" means, for chemicals of concern, the Criteria for Chemical Constituents in Table 1 of rule 567—61.3(455B), except that "1,000 ug/L" will be substituted for the chronic levels for toluene for Class B designated use segments.

"Surface water pathway" means a pathway which leads to a surface water body.

"Tank" is a stationary device designed to contain an accumulation of regulated substances and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

"Target level" means the allowable concentrations of chemicals of concern established to achieve an applicable target risk which must be met at the point(s) of compliance as specified in these rules.

"Target risk" refers to an applicable carcinogenic and noncarcinogenic risk factor designated in these rules and used in determining target levels (for carcinogenic risk assessment, target risk is a separate factor, different from exposure factors, both of which are used in determining target levels).

"Technological controls" means a physical action which does not involve source removal or reduction, but severs or reduces exposure to a receptor, such as caps, containment, carbon filters, point of use water treatment, etc.

"Tier 1 level" means the groundwater and soil levels in the Tier 1 Look-up Table set out in rule 135.9(455B) and Appendix A.

"Tier 1 site assessment" means the evaluation of limited site-specific data compared to the Tier 1 levels established in these rules for the purpose of determining which pathways do not require assessment and evaluation at Tier 2 and which sites warrant a no further action required classification without further assessment and evaluation.

"Tier 2 site assessment" means the process of assessing risk to actual and potential receptors by using site-specific field data and designated Tier 2 exposure and fate and transport models to determine the applicable target level(s).

"Tier 3 site assessment" means a site-specific risk assessment utilizing more sophisticated data or analytic techniques than a Tier 2 site assessment.

"Under-dispenser containment (UDC)" means containment underneath a dispenser that will prevent leaks from the dispenser from reaching soil or groundwater. Such containment must:

- Be intact and liquid-tight on its sides and bottom and at any penetrations;
- Be compatible with the substance conveyed by the piping; and
- Allow for visual inspection and monitoring and access to the components in the containment system.

"Underground area" means an underground room, such as a basement, cellar, shaft or vault, providing enough space for physical inspection of the exterior of the tank situated on or above the surface of the floor.

"Underground release" means any below-ground release.

"Underground storage tank" or *"UST"* means any one or combination of tanks (including underground pipes connected thereto) that is used to contain an accumulation of regulated substances, and the volume of which (including the volume of underground pipes connected thereto) is 10 percent or more beneath the surface of the ground. This term does not include any:

a. Farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes. Iowa Code section 455B.471 requires those tanks existing prior to July 1, 1987, to be registered. Tanks installed on or after July 1, 1987, must comply with all 567—Chapter 135 rules;

b. Tank used for storing heating oil for consumptive use on the premises where stored;

c. Septic tank;

d. Pipeline facility (including gathering lines) regulated under:

(1) The Natural Gas Pipeline Safety Act of 1968 (49 U.S.C. App. 1671, et seq.), or

(2) The Hazardous Liquid Pipeline Safety Act of 1979 (49 U.S.C. App. 2001, et seq.), or

(3) Which is an intrastate pipeline facility regulated under state laws comparable to the provisions of the law referred to in *"d"*(1) or *"d"*(2) of this definition;

e. Surface impoundment, pit, pond, or lagoon;

f. Storm-water or wastewater collection system;

g. Flow-through process tank;

h. Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations; or

i. Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor.

The term "underground storage tank" or "UST" does not include any pipes connected to any tank which is described in paragraphs *"a"* through *"j"* of this definition.

"Underground utility vault" means any constructed space accessible for inspection and maintenance associated with subsurface utilities.

"Unreasonable risk to public health and safety or the environment" means the Tier 1 levels for a Tier 1 site assessment, the applicable target level for a Tier 2 site assessment, and the applicable target level for a Tier 3 site assessment.

"Upgrade" means the addition or retrofit of some systems such as cathodic protection, lining, or spill and overfill controls to improve the ability of an underground storage tank system to prevent the release of product.

"UST system" or *"tank system"* means an underground storage tank, connected underground piping, underground ancillary equipment, and containment system, if any.

"Utility envelope" means the backfill and trench used for any subsurface utility line, drainage system and tile line.

"Wastewater treatment tank" means a tank that is designed to receive and treat an influent wastewater through physical, chemical, or biological methods.

[**ARC 7621B**, IAB 3/11/09, effective 4/15/09; **ARC 8124B**, IAB 9/9/09, effective 10/14/09]

567—135.3(455B) UST systems—design, construction, installation and notification.

135.3(1) *Performance standards for new UST systems.* In order to prevent releases due to structural failure, corrosion, or spills and overfills for as long as the UST system is used to store regulated substances, all owners and operators of new UST systems must meet the following requirements.

a. Tanks. Each tank must be properly designed and constructed, and any portion underground that routinely contains product must be protected from corrosion, in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

(1) The tank is constructed of fiberglass-reinforced plastic; or

NOTE: The following industry codes may be used to comply with 135.3(1)*"a"*(1): Underwriters Laboratories Standard 1316, "Standard for Glass-Fiber-Reinforced Plastic Underground Storage Tanks for Petroleum Products"; Underwriters Laboratories of Canada CAN4-S615-M83, "Standard for Reinforced Plastic Underground Tanks for Petroleum Products"; or American Society of Testing and Materials Standard D4021-86, "Standard Specification for Glass-Fiber-Reinforced Polyester Underground Petroleum Storage Tanks."

(2) The tank is constructed of steel and cathodically protected in the following manner:

1. The tank is coated with a suitable dielectric material;
2. Field-installed cathodic protection systems are designed by a corrosion expert;
3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2)*"c"*; and
4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or according to guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"a"*(2): Steel Tank Institute "Specification for STI-P3 System of External Corrosion Protection of Underground Steel Storage Tanks"; Underwriters Laboratories Standard 1746, "Corrosion Protection Systems for Underground Storage Tanks"; Underwriters Laboratories of Canada CAN4-S603-M85, "Standard for Steel Underground Tanks for Flammable and Combustible Liquids," and CAN4-GO3.1-M85, "Standard for Galvanic Corrosion Protection Systems for Underground Tanks for Flammable and Combustible Liquids," and CAN4-S631-M84, "Isolating Bushings for Steel Underground Tanks Protected with Coatings and Galvanic Systems"; or National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," and Underwriters Laboratories Standard 58, "Standard for Steel Underground Tanks for Flammable and Combustible Liquids."

(3) The tank is constructed of a steel-fiberglass-reinforced plastic composite; or

NOTE: The following industry codes may be used to comply with 135.3(1)*"a"*(3): Underwriters Laboratories Standard 1746, "Corrosion Protection Systems for Underground Storage Tanks," or the Association for Composite Tanks ACT-100, "Specification for the Fabrication of FRP Clad Underground Storage Tanks."

(4) The tank is constructed of metal without additional corrosion protection measures provided that:

1. The tank is installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life; and
2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1)*"a"*(4)"1" for the remaining life of the tank; or

(5) The tank construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than 135.3(1)*"a"*(1) to (4).

b. Piping. The piping that routinely contains regulated substances and is in contact with the ground must be properly designed, constructed, and protected from corrosion in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

(1) The piping is constructed of fiberglass-reinforced plastic; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"b"*(1): Underwriters Laboratories Subject 971, "UL Listed Non-Metal Pipe"; Underwriters Laboratories Standard 567, "Pipe Connectors for Flammable and Combustible and LP Gas"; Underwriters Laboratories of Canada Guide ULC-107, "Glass Fiber Reinforced Plastic Pipe and Fittings for Flammable Liquids"; and Underwriters Laboratories of Canada Standard CAN 4-S633-M81, "Flexible Underground Hose Connectors."

(2) The piping is constructed of steel and cathodically protected in the following manner:

1. The piping is coated with a suitable dielectric material;
2. Field-installed cathodic protection systems are designed by a corrosion expert;
3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2)*"c"*; and
4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"b"*(2): National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; American Petroleum Institute Publication 1615, "Installation of Underground Petroleum Storage Systems"; American Petroleum Institute Publication 1632, "Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems."

(3) The piping is constructed of metal without additional corrosion protection measures provided that:

1. The piping is installed at a site that is determined by a corrosion expert to not be corrosive enough to cause it to have a release due to corrosion during its operating life; and
2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1)*"b"*(3)"1" for the remaining life of the piping; or

NOTE: National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems," may be used to comply with 135.3(1)*"b"*(3).

(4) The piping construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than the requirements in 135.3(1)*"b"*(1) to (3).

c. Spill and overfill prevention equipment.

(1) Except as provided in subparagraph (2), to prevent spilling and overfilling associated with product transfer to the UST system, owners and operators must use the following spill and overfill prevention equipment:

1. Spill prevention equipment that will prevent release of product to the environment when the transfer hose is detached from the fill pipe (for example, a spill catchment basin); and
2. Overfill prevention equipment that will:

Automatically shut off flow into the tank when the tank is no more than 95 percent full; or

Alert the transfer operator when the tank is no more than 90 percent full by restricting the flow into the tank or triggering a high-level alarm; or

Restrict flow 30 minutes prior to overfilling, alert the operator with a high-level alarm one minute before overfilling, or automatically shut off the flow into the tank so that none of the fittings located on top of the tank are exposed to product due to overfilling.

(2) Owners and operators are not required to use the spill and overfill prevention equipment specified in subparagraph (1) if:

1. Alternative equipment is used that is determined by the department to be no less protective of human health and the environment than the equipment specified in subparagraph (1)"1" or "2" of this paragraph; or
2. The UST system is filled by transfers of no more than 25 gallons at one time.

d. Installation. All tanks and piping must be properly installed in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and in accordance with the manufacturer's instructions.

NOTE: Tank and piping system installation practices and procedures described in the following codes may be used to comply with the requirements of 135.3(1)*"d"*: American Petroleum Institute Publication 1615, "Installation of Underground Petroleum Storage System"; Petroleum Equipment Institute Publication RP100, "Recommended Practices for Installation of Underground Liquid Storage Systems"; or American National Standards Institute Standard 831.3, "Petroleum Refinery Piping," and American National Standards Institute Standard 831.4, "Liquid Petroleum Transportation Piping System."

e. Certification of installation. All owners and operators must ensure that one or more of the following methods of certification, testing, or inspection is used to demonstrate compliance with paragraph *"d"* of this subrule by providing a certification of compliance on the UST notification form in accordance with 135.3(3).

(1) The installer has been certified by the tank and piping manufacturers; or

(2) The installer has been certified or licensed by the department as provided in 567—Chapter 134, Part C; or

(3) The installation has been inspected and certified by a registered professional engineer with education and experience in UST system installation; or

(4) The installation has been inspected and approved by an inspector certified or licensed by the Iowa comprehensive petroleum underground storage tank fund board; or

(5) All work listed in the manufacturer's installation checklists has been completed; or

(6) The owner and operator have complied with another method for ensuring compliance with paragraph *"d"* that is determined by the department to be no less protective of human health and the environment.

135.3(2) *Upgrading of existing UST systems.*

a. Alternatives allowed. Not later than December 22, 1998, all existing UST systems must comply with one of the following requirements:

(1) New UST system performance standards under 135.3(1);

(2) The upgrading requirements in paragraphs *"b"* through *"d"* below; or

(3) Closure requirements under rule 135.15(455B), including applicable requirements for corrective action under rules 135.7(455B) to 135.12(455B).

Replacement or upgrade of a tank system on a petroleum contaminated site classified as a high or low risk in accordance with subrule 135.12(455B) shall be a double wall tank or a tank equipped with a secondary containment system with monitoring of the space between the primary and secondary containment structures in accordance with 135.5(4)*"g"* or other approved tank system or methodology approved by the Iowa comprehensive petroleum underground storage tank fund board.

b. Tank upgrading requirements. Steel tanks must be upgraded to meet one of the following requirements in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory:

(1) *Interior lining.* A tank may be upgraded by internal lining if:

1. The lining is installed in accordance with the requirements of 135.4(4), and

2. Within ten years after lining, and every five years thereafter, the lined tank is internally inspected and found to be structurally sound with the lining still performing in accordance with original design specifications.

(2) *Cathodic protection.* A tank may be upgraded by cathodic protection if the cathodic protection system meets the requirements of 135.3(1)*"a"*(2)"2," "3," and "4" and the integrity of the tank is ensured using one of the following methods:

1. The tank is internally inspected and assessed to ensure that the tank is structurally sound and free of corrosion holes prior to installing the cathodic protection system; or

2. The tank has been installed for less than ten years and is monitored monthly for releases in accordance with 135.5(4)*"d"* through *"h"*; or

3. The tank has been installed for less than ten years and is assessed for corrosion holes by conducting two tightness tests that meet the requirements of 135.5(4)*"c."* The first tightness test must be conducted prior to installing the cathodic protection system. The second tightness test must be

conducted between three and six months following the first operation of the cathodic protection system; or

4. The tank is assessed for corrosion holes by a method that is determined by the department to prevent releases in a manner that is no less protective of human health and the environment than 135.3(2)*"b"*(2)"1" to "3."

(3) *Internal lining combined with cathodic protection.* A tank may be upgraded by both internal lining and cathodic protection if:

1. The lining is installed in accordance with the requirements of 135.4(4); and

2. The cathodic protection system meets the requirements of 135.3(1)*"a"*(2)"2," "3," and "4."

NOTE: The following codes and standards may be used to comply with subrule 135.3(2): American Petroleum Institute Publication 1631, "Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks"; National Leak Prevention Association Standard 631, "Spill Prevention, Minimum 10-Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection"; National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems"; and American Petroleum Institute Publication 1632, "Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems."

c. Piping upgrading requirements. Metal piping that routinely contains regulated substances and is in contact with the ground must be cathodically protected in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and must meet the requirements of 135.3(1)*"b"*(2)"2," "3," and "4."

NOTE: The codes and standards listed in the note following 135.3(1)*"b"*(2) may be used to comply with this requirement.

d. Spill and overfill prevention equipment. To prevent spilling and overfilling associated with product transfer to the UST system, all existing UST systems must comply with new UST system spill and overfill prevention equipment requirements specified in 135.3(1)*"c."*

135.3(3) *Notification requirements.*

a. Except as provided in 135.3(3)*"b,"* the owner of an underground storage tank existing on or before July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 1, 1986.

b. The owner of an underground storage tank taken out of operation between January 1, 1974, and July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 8, 1986, unless the owner knows the tank has been removed from the ground. For purposes of this subrule, "owner" means the person who owned the tank immediately before the discontinuation of the tank's use.

c. An owner or operator who brings into use an underground storage tank after July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department within 30 days of installing the tank in the ground. The owner or operator shall not allow the deposit of any regulated substance into the tank without prior approval of the department or until the tank has been issued a tank registration tag and is covered by an approved financial responsibility mechanism in accordance with 567—Chapter 136.

d. All owners and operators of new UST systems must certify in the notification form compliance with the following requirements:

(1) Installation of tanks and piping under 135.3(1)*"e"*;

(2) Cathodic protection of steel tanks and piping under 135.3(1)*"a"* and *"b"*;

(3) Financial responsibility under 567—Chapter 136, Iowa Administrative Code;

(4) Release detection under 135.5(2) and 135.5(3).

e. All owners and operators of new UST systems must ensure that the installer certifies in the notification form that the methods used to install the tanks and piping comply with the requirements in 135.3(1)*"d."*

f. Exemption from reporting requirement. Paragraphs *"a"* to *"c"* do not apply to an underground storage tank for which notice was given pursuant to Section 103, Subsection c, of the Comprehensive Environmental Response, Compensation and Liabilities Act of 1980. (42 U.S.C. Subsection 9603(c))

g. Reporting fee. The notice by the owner to the department under paragraphs *"a"* to *"c"* shall be accompanied by a fee of $10 for each tank included in the notice.

h. Notification requirement for installing a tank. A person installing an underground storage tank and the owner or operator of the underground storage tank must notify the department of their intent to install the tank 30 days prior to installation. Notification shall be on a form provided by the department.

i. Notification requirements for a person who sells, installs, modifies or repairs a tank. A person who sells, installs, modifies, or repairs a tank used or intended to be used in Iowa shall notify, in writing, the purchaser and the owner or operator of the tank of the obligations specified in paragraphs 135.3(3)*"c"* and *"j"* and the financial assurance requirements in 567—Chapter 136. The notification must include the prohibition on depositing a regulated substance into tanks which have not been registered and issued tags by the department. A standard notification form supplied by the department may be used to satisfy this requirement.

j. It is unlawful for a person to deposit or accept a regulated substance in an underground storage tank that has not been registered and issued permanent or annual tank management tags in accordance with rule 567—135.3(455B). It is unlawful for a person to deposit or accept a regulated substance into an underground storage tank if the person has received notice from the department that the underground storage tank is subject to a delivery prohibition or if there is a "red tag" attached to the UST fill pipe or fill pipe cap as provided in subrule 135.3(8).

(1) The department may provide written authorization to receive a regulated substance when there is a delay in receiving tank tags or at new tank installations to allow for testing the tank system.

(2) The department may provide known depositors of regulated substances lists of underground storage tank sites that have been issued tank tags, those that have not been issued tank tags, and those subject to a delivery prohibition pursuant to subrule 135.3(8). These lists do not remove the requirement for depositors to verify that current tank tags are affixed to the fill pipe prior to delivering product. Regulated substances cannot be delivered to underground storage tanks without current tank tags or those displaying a delivery prohibition "red tag" as provided in subrule 135.3(8).

(3) A person shall not deposit a regulated substance in an underground storage tank after receiving written or oral notice from the department that the tank is not covered by an approved form of financial responsibility in accordance with 567—Chapter 136.

k. If an owner or operator fails to register an underground storage tank within 30 days after installation or obtain annual renewal tags by April 1, the owner or operator shall pay an additional $250 upon registration of the tank or application for tank tag renewal. The imposition of this fee does not preclude the department from assessing an additional administrative penalty in accordance with Iowa Code section 455B.476.

135.3(4) *Farm and residential tanks.*

a. The owner or operator of a farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes is subject to the requirements of this subrule.

b. Farm and residential tanks, installed before July 1, 1987, shall be reported on a notification form by July 1, 1989, but owners or operators are not required to pay a registration fee.

c. Farm and residential tanks that were installed on or after July 1, 1987, shall be in compliance with all the underground storage tank regulations.

135.3(5) *Registration tags and annual management fee.*

a. Tanks of 1100 gallons or less capacity that have registered with the department will be issued a permanent registration tag.

b. The owner or operator of tanks over 1100-gallon capacity must submit a tank management fee of $65 per tank by January 15 of each year. The owner or operator must also submit written proof that the tanks are covered by an approved form of financial responsibility in accordance with 567—Chapter 136. Upon proper payment of the fee and acceptable proof of financial responsibility, a one-year registration

tag will then be issued for the period from April 1 to March 31. The department shall refund a tank management fee if the tank is permanently closed prior to the effective date of April 1 for that year.

c. The owner or operator shall affix the tag to the fill pipe of the underground storage tank where it will be readily visible.

d. A person who conveys or deposits a regulated substance shall inspect the underground storage tank to determine the existence or absence of a current registration tag, a current annual tank management fee tag, or a delivery prohibition "red tag" as provided in subrule 135.3(8). If the tag is not affixed to the fill pipe or fill pipe cap or if a delivery prohibition "red tag" is displayed, the person shall not deposit the substance in the tank.

e. The owner or operator must return the tank tags upon request of the department for failure to meet the requirements of rules 135.3(455B) to 135.5(455B) or the financial responsibility rules in 567—Chapter 136 after permanent tank closure or when tanks are temporarily closed for over 12 months, or when the tank system is suspected to be leaking and the responsible party fails to respond as required in subrule 135.8(1). The department will not return the tags until the tank system is in full compliance with the technical requirements of this chapter and financial responsibility requirements of 567—Chapter 136.

135.3(6) *Petroleum underground storage tank registration amnesty program.*

a. A petroleum underground storage tank required to be registered under 135.3(3) and 135.3(4), which has not been registered prior to July 1, 1988, may be registered under the following conditions:

(1) The tank registration fee under 135.3(3)*"g"* shall accompany the registration.

(2) The storage tank management fee under 135.3(5) shall be paid for past years in which the tank should have been registered.

b. If a tank is registered under this subrule on or prior to October 1, 1989, penalties under Iowa Code section 455B.477 shall be waived.

135.3(7) *Exemption certificates from the environmental charge on petroleum diminution.*

a. An owner or operator of a petroleum underground storage tank that is exempt, deferred, or excluded from regulation under Iowa Code sections 455G.1 to 455G.17, can apply for an exemption certificate from the department to exempt a tank from the environmental charge on petroleum diminution. Exempted tanks include those listed in 135.1(3)*"b"* and *"c"* and those excluded in the definition of "underground storage tank" in 135.2(455B). Application for the exemption certificate shall be made on the form provided by the department.

b. An exemption certificate is not required for those classes of tanks that the Iowa comprehensive petroleum underground storage tank fund board has waived from the exemption certificate requirement.

c. The department shall revoke and require the return of the exemption certificate if the petroleum underground storage tank becomes subject to Iowa Code sections 455G.1 to 455G.17.

135.3(8) *Delivery prohibition process.*

a. Identifying sites subject to delivery response prohibition action.

(1) Annual registration tag and tank management fee process. Owners and operators shall certify to the following on a form prepared by the department when applying for annual tank tags pursuant to subrule 135.3(5):

1. Installation and performance of an approved UST and piping release detection method as provided in rule 135.5(455B), including an annual line tightness test and a line leak detector test if applicable.

2. Installation of an approved overfill and spill protection system as provided in paragraph 135.3(1)*"c."*

3. Installation of an approved corrosion protection system as provided in paragraphs 135.3(1)*"a"* and *"b."*

4. If the UST system has been out of operation for more than three months, that the UST system has been temporarily closed in accordance with rule 135.15(455B) and a certification of temporary closure has been submitted to the department.

5. If the UST system has been removed or filled in place within the last 12 months, the date of removal or filling in place and whether a closure report has been submitted as provided in rule 135.15(455B).

(2) Sites with provisional status. If the UST system has been classified as operating under provisional status as provided in paragraph 135.3(8)*"c,"* owners and operators when applying for annual tank tags pursuant to subrule 135.3(5) must certify on a form prepared by the department that the owners and operators are in compliance with an approved provisional status remedial plan as provided in paragraph 135.3(8)*"c."*

(3) Compliance inspections. The department may initiate a delivery prohibition response action based on: (1) a finding resulting from a third-party compliance inspection conducted pursuant to rule 135.20(455B); (2) a department investigation and inspection conducted pursuant to Iowa Code section 455B.475; or (3) review of a UST system check or other documentation submitted in response to a suspected release under rule 135.6(455B) or in response to a confirmed release under rule 135.7(455B).

b. Delivery prohibition eligibility criteria. A delivery prohibition response action may be initiated upon a finding that the UST system is out of compliance with department rules and meets the eligibility criteria as specified below. Reinstatement criteria define the standards and process for owners and operators to document that they have taken corrective action sufficient to authorize resumption of fuel to the USTs. Prior to initiation of the delivery prohibition, owners and operators are afforded a minimum level of procedural due process such as prior notice and the opportunity to present facts to dispute the finding. Where notice and the opportunity to take corrective action prior to initiation of a delivery prohibition response action are required, notice by the department or by a certified compliance inspector as provided in rule 135.20(455B) shall be sufficient.

If the department finds that any one of the following criteria has been satisfied, the department may initiate a delivery prohibition response action following the notice procedures outlined in paragraph *"e"* of this subrule. After initiation of the delivery prohibition response action, the department will offer the owner or operator an opportunity to establish reinstatement criteria by written documentation and, if requested, an in-person meeting.

(1) An approved release detection method for USTs or UST piping is not installed, such as automatic tank gauging, groundwater monitoring wells and line leak detectors, and there is no record that an approved method such as inventory control, statistical inventory reconciliation, or interstitial space monitoring has been employed during the previous three months. If the owner or operator claims to have documentation that an approved release detection method has been conducted, the owner or operator will be given two business days to produce the documentation.

REINSTATEMENT CRITERIA: The owner or operator must submit results of a passing UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."* The owner or operator must also document installation and operation of an approved release detection system. This may include proof that a contract has been signed with a qualified statistical inventory reconciliation provider or that a qualified inventory control method has been implemented and training has been provided to onsite supervisory personnel.

(2) No documentation of a required annual line tightness test or line leak detector test has been provided, and the owner or operator has failed to conduct the required testing within 14 days of written notice by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERIA: The owner or operator must provide documentation of a passing line precision tightness test at the 0.1 gallon-per-hour leak rate in paragraph 135.5(5)*"b"* and a line leak detector test as provided in paragraph 135.5(5)*"a."*

(3) Overfill and spill protection is not installed.

REINSTATEMENT CRITERION: The owner or operator must provide documentation that overfill and spill protection equipment has been installed.

(4) A corrosion protection system is not installed or there is no record that an impressed current corrosion protection system has been in operation for the prior six months.

REINSTATEMENT CRITERIA: A manned entry tank integrity inspection must be completed prior to installation of a corrosion protection system, and the owner or operator must submit results of a passing

UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."* A corrosion protection analysis must be completed and approved by the department.

(5) The owner or operator has failed to provide proof of financial responsibility in accordance with 567—Chapter 136.

REINSTATEMENT CRITERION: The owner or operator must submit acceptable proof of financial responsibility in accordance with 567—Chapter 136.

(6) A qualified UST system release detection method is installed and is being used but the documentation or the absence of documentation is sufficient to question the reliability of the release detection over the past 12-month period. The owner or operator shall be notified of the deficiencies, shall be given at least two business days to produce documentation of compliance and, if necessary, shall be required to conduct a leak detection system analysis and a system tightness test within 14 days. If the owner or operator fails to produce documentation of compliance or to conduct the system analysis and the UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b,"* the department may initiate a delivery prohibition response action. Notice by the department or a compliance inspector as provided in rule 135.20(455B) shall be sufficient to initiate a delivery prohibition response action.

REINSTATEMENT CRITERIA: The owner or operator must submit documentation that the leak detection method analysis sufficiently documents compliance and explains the reasons for the accuracy and reliability concerns. If necessary, the owner or operator must submit passing results of a UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."*

(7) The owner or operator has failed to document completion of a three-year corrosion protection test or to repair defective corrosion protection equipment within 30 days after notice of the violation by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERION: The owner or operator must submit documentation of a three-year corrosion protection test as provided in rule 135.3(455B).

(8) The owner or operator has failed to complete a compliance inspection required by rule 135.20(455B) within 60 days after written notice of the violation by the department.

REINSTATEMENT CRITERION: The owner or operator must submit a compliance inspection report as provided in rule 135.20(455B).

(9) The owner or operator has failed to take necessary abatement action in response to a confirmed release as provided in subrules 135.7(2) and 135.7(3).

REINSTATEMENT CRITERION: The owner or operator must document compliance with the abatement provisions in subrules 135.7(2) and 135.7(3).

(10) The owner or operator has failed to undertake and document release investigation and confirmation steps within seven days in response to a suspected release as provided in paragraph 135.6(3)*"a."*

REINSTATEMENT CRITERION: The owner or operator must document release confirmation and system check as provided in paragraph 135.6(3)*"a."*

c. Provisional status. The department may classify a UST system as operating under a provisional status when the department documents a pattern of UST operation and maintenance violations under rules 135.3(455B) through 135.5(455B) and suspected release and confirmed release response actions under rules 135.6(455B) and 135.7(455B). The department shall provide the owner or operator with a notice specifying the basis for the proposed classification and a proposed remedial action plan. The objective of the remedial action plan is to provide the owner and operator an opportunity to undertake certain remedial actions sufficient to establish a reasonable likelihood that future regulatory compliance will be achieved.

The remedial action plan may include but is not limited to provisions for owner/operator training, development of a facility-specific compliance manual, more frequent third-party compliance inspections than otherwise required under rule 135.20(455B), monthly reporting, and retention of a third-party compliance manager/consultant. If the owner or operator and the department cannot reach agreement on a remedial action plan, the department may initiate enforcement action by issuance of an administrative

order pursuant to 567—Chapter 10. This provision does not grant the owner or operator an entitlement to this procedure, and the department reserves all discretion to undertake an enforcement action and assess penalties as provided in Iowa Code sections 455B.476 and 455B.477.

d. Administrative orders. The department may impose a delivery prohibition as a remedy for violations of the operation and maintenance provisions in rules 135.3(455B) through 135.5(455B) and the suspected and confirmed release response actions in rules 135.6(455B) and 135.7(455B). This remedy may be in addition to the assessment of penalties as provided in Iowa Code section 455B.476 and other appropriate injunctive relief necessary to correct violations.

e. Due process prior to initiation of a delivery prohibition response action.

(1) Prior to imposing a delivery prohibition response action under paragraph 135.3(8)*"b"* above, the department will provide notice to the owner or operator or, if notice to the owner or operator cannot be confirmed, to a person in charge at the UST facility of the basis for the finding and the intent to initiate a delivery prohibition response action. Notice may be by verbal contact, by facsimile, or by regular or certified mail to the UST facility address or the owner's or operator's last-known address. The owner and operator will be given a minimum of one business day to provide documentation that the finding is inaccurate or that reinstatement criteria in subparagraphs 135.3(8)*"b"*(1) through (5) have been satisfied. Additional days and the opportunity for a telephone or in-person conference may be provided the owner and operator to contest the factual basis for a finding under subparagraphs 135.3(8)*"b"*(6) through (10). Additional procedural due process may be afforded the owner and operator on a case-by-case basis sufficient to satisfy Constitutional due process standards.

If insufficient information is submitted to change the finding, the department will notify the owner or operator and a person in charge at the UST facility of the final decision to impose the delivery prohibition response action.

(2) Provisional status. Upon a finding that an owner or operator under provisional status has failed to comply with the terms of a remedial action plan as provided above, the department may initiate a delivery prohibition response action by giving actual notice to the owner or operator of the basis for the finding of noncompliance and the department's intent to initiate a delivery prohibition response action. The delivery prohibition response action shall not be imposed without providing the owner or operator the opportunity for an evidentiary hearing consistent with the provisions for suspension and revocation of licenses under 567—Chapter 7.

f. Delivery prohibition procedure. Upon oral or written notice that the delivery prohibition response action has been imposed, the owner or operator and any person in charge of the UST facility shall be notified that they are not authorized to receive any further delivery of regulated substances until conditions for reinstatement of eligibility are satisfied. Owners and operators are required to immediately remove and return to the department the current annual tank management fee tags or the tank registration tags if there are no tank management fee tags. Owners and operators are required to provide the department with names and contact information for all persons who convey or deposit regulated substances to the USTs. The department will attempt to notify known persons who convey or deposit regulated substances to the USTs that they are not authorized to deliver to the USTs until further notice by the department as provided in paragraph 135.3(3)*"j"* and subrule 135.3(5).

If the tank tags are not returned within three business days, the department shall visit the site, remove the tags, and affix a "red tag" to the fill pipes or fill pipe caps of all affected USTs. It is unlawful for any person to deposit or accept a regulated substance into a UST that has a "red tag" affixed to the fill pipe or fill pipe cap. The department may allow the owner and operator to dispense and sell the remainder of existing fuel unless the department determines there is an immediate risk of a release or other risk to human health, safety or the environment. The department shall confirm in writing the basis for the delivery prohibition response action, contacts made prior to the action, and steps the owner or operator must take to reinstate fuel delivery.

135.3(9) *Secondary containment requirements for new and replacement UST system installations.* All new and replacement underground storage tank systems and appurtenances used for the storage and dispensing of petroleum products installed after November 28, 2007, shall have secondary containment in accordance with this subrule. The secondary containment provision includes

the installation of turbine sumps, transition or intermediate sumps and under-dispenser containment (UDC).

a. The secondary containment may be manufactured as an integral part of the primary containment or constructed as a separate containment system.

b. Installation of any new or replacement turbine pumps involving the direct connection to the tank shall have secondary containment.

c. Any replacement of ten feet or more of piping shall have secondary containment.

d. All piping replacements requiring secondary containment shall be constructed with transition or intermediate containment sumps.

e. The design and construction of all primary and secondary containment shall meet the performance standards in subrule 135.3(1) and paragraphs 135.5(3)*"b"* and 135.5(4)*"g."* At a minimum, the secondary containment must:

(1) Contain regulated substances released from the tank system until detected and removed;

(2) Prevent the release of regulated substances into the environment at any time during the operational life of the underground storage tank system; and

(3) Be checked for evidence of a release at least every 30 days as provided in paragraph 135.5(2)*"a."*

f. Secondary containment with interstitial monitoring in accordance with paragraphs 135.5(3)*"b,"*135.5(4)*"g"* and 135.5(5)*"d"* shall become the primary method of leak detection for all new and replacement tanks and piping installed after November 28, 2007.

g. Testing and inspection. Secondary containment systems shall be liquid-tight and must be inspected and tested every two years. The sensing devices must be tested every two years.

(1) Inspections for secondary containment sumps (spill catchment basins, turbine sumps, transition or intermediate sumps, and under-dispenser containment) shall:

1. Consist of a visual inspection by an Iowa-licensed installer or Iowa-certified inspector every two years. Sumps must be intact (no cracks or perforations) and liquid-tight, including sides and bottom.

2. Sumps must be maintained and kept free of debris, liquid and ice at all times.

3. Regulated substances spilled into any spill catchment basin, turbine sump, transition/intermediate sump or under-dispenser containment shall be immediately removed.

(2) Sensing devices used to monitor the interstitial space shall be tested at least every two years for proper function.

h. Under-dispenser containment. When installing a new motor fuel dispenser or replacing a motor fuel dispenser, a UDC shall be installed whenever:

(1) A motor fuel dispenser is installed at a location where there previously was no dispenser (new UST system or new dispenser location at an existing UST system); or

(2) An existing motor fuel dispenser is removed and replaced with another dispenser and the equipment used to connect the dispenser to the underground storage tank system is replaced. This equipment includes flexible connectors or risers or other transitional components that are beneath the dispenser and connect the dispenser to the piping. A UDC is not required when only the emergency shutoff or shear valves or check valves are replaced.

(3) A UDC shall also be installed beneath the motor fuel dispenser whenever ten feet or more of piping is repaired or replaced within ten feet of a motor fuel dispenser.

i. Exceptions from secondary containment standards. A tank owner or operator may request an exception from the secondary containment standard if the location of the UST system is greater than 1,000 feet from a community water system or potable drinking water well. A community water system includes the distribution piping.

(1) "Community water system (CWS)" means a public water system which has at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents. "Public water supply system" means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year. Such term includes: any collection, treatment, storage, and distribution facilities under control of the operator of

such system and used primarily in connection with such system; and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Such term does not include any "special irrigation district." A "public water supply system" is either a "community water system" or a "noncommunity water system."

(2) "Potable drinking water well" means any hole (dug, driven, drilled, or bored) that extends into the earth until it meets groundwater and that supplies water for a noncommunity public water system or supplies water for household use (consisting of drinking, bathing, and cooking or other similar uses). Such wells may provide water to entities such as a single-family residence, a group of residences, businesses, schools, parks, campgrounds, and other permanent or seasonal communities. A "noncommunity water system" is defined in rule 567—40.2(455B) as a public water system that is not a community water system. A "noncommunity water system" is either a "transient noncommunity water system (TNC)" or a "nontransient noncommunity water system (NTNC)."

(3) To determine if a new or replacement underground storage tank, piping, or motor fuel dispenser system is within 1,000 feet of an existing community water system or an existing potable drinking water well, at a minimum the distance must be measured from the closest part of the new or replacement underground storage tank or piping or the motor fuel dispenser system to:

1. The closest part of the nearest existing community water system, including:

- The location of the wellhead(s) for groundwater and the location of the intake point(s) for surface water;
- Water lines, processing tanks, and water storage tanks; and
- Water distribution/service lines under the control of the community water system operator.

2. The wellhead of the nearest existing potable drinking water well.

(4) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing community water system will be installed, and a community water system that will be within 1,000 feet of the UST system is planned or a permit application has been submitted to the department under 567—Chapter 40, secondary containment and under-dispenser containment are required unless the permit is denied.

(5) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing potable drinking water well will be installed and the owner will be installing a potable drinking water well at the new facility, or a private water well permit has been submitted pursuant to 567—Chapter 38 and pursuant to applicable county and municipal ordinances for a potable drinking water well that will be within 1,000 feet of the UST system, secondary containment and under-dispenser containment are required unless the permit is denied.

j. Documentation for exception from secondary containment. The following documentation must be provided by the tank owner or operator when requesting an exception from the UST system secondary containment requirement.

(1) A statement from the manager of the local community water system that the community water system is not located or planned within 1,000 feet of the UST system location. This would include rural water systems.

(2) A map showing homes and businesses within 1,000 feet of the UST system location.

(3) Identification of the source of water for the business at the UST system location.

(4) The results of an on-foot search around businesses and homes within a 1,000-foot radius for possible potable drinking water wells. Documentation that there are no pending nonpublic water well permit applications within 1,000 feet of the UST system from any applicable municipal permitting authority, county department of health with department-delegated authority, or the department if there is not delegated permitting authority.

(5) Search results from the Geographic Information System (GIS) well mapping for well locations available from the Iowa Geological Survey.

(6) Documentation that the department's water supply section has no pending applications for a public water supply construction permit within 1,000 feet of a proposed UST system installation or replacement or motor fuel dispenser installation or replacement.

567—135.4(455B) General operating requirements.

135.4(1) *Spill and overfill control.*

a. Owners and operators must ensure that releases due to spilling or overfilling do not occur. The owner and operator must ensure that the volume available in the tank is greater than the volume of product to be transferred to the tank before the transfer is made and that the transfer operation is monitored constantly to prevent overfilling and spilling.

NOTE: The transfer procedures described in National Fire Protection Association Publication 385 may be used to comply with 135.4(1)*"a."* Further guidance on spill and overfill prevention appears in American Petroleum Institute Publication 1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," and National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code."

b. The owner and operator must report, investigate, and clean up any spills and overfills in accordance with 135.6(4).

135.4(2) *Operation and maintenance of corrosion protection.* All owners and operators of steel UST systems with corrosion protection must comply with the following requirements to ensure that releases due to corrosion are prevented for as long as the UST system is used to store regulated substances:

a. All corrosion protection systems must be operated and maintained to continuously provide corrosion protection to the metal components of that portion of the tank and piping that routinely contain regulated substances and are in contact with the ground.

b. All UST systems equipped with cathodic protection systems must be inspected for proper operation by a qualified cathodic protection tester in accordance with the following requirements:

(1) *Frequency.* All cathodic protection systems must be tested within six months of installation and at least every three years thereafter or according to another reasonable time frame established by the department; and

(2) *Inspection criteria.* The criteria that are used to determine that cathodic protection is adequate as required by this subrule must be in accordance with a code of practice developed by a nationally recognized association.

NOTE: National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," may be used to comply with 135.4(2)*"b"*(2).

c. UST systems with impressed current cathodic protection systems must also be inspected every 60 days to ensure the equipment is running properly.

d. For UST systems using cathodic protection, records of the operation of the cathodic protection must be maintained (in accordance with 135.4(5)) to demonstrate compliance with the performance standards in this subrule. These records must provide the following:

(1) The results of the last three inspections required in paragraph *"c"*; and

(2) The results of testing from the last two inspections required in paragraph *"b."*

135.4(3) *Compatibility.* Owners and operators must use a UST system made of or lined with materials that are compatible with the substance stored in the UST system.

NOTE: Owners and operators storing alcohol blends may use the following codes to comply with the requirements of subrule 135.4(3): American Petroleum Institute Publication 1626, "Storing and Handling Ethanol and Gasoline-Ethanol Blends at Distribution Terminals and Service Stations"; and American Petroleum Institute Publication 1627, "Storage and Handling of Gasoline-Methanol/Cosolvent Blends at Distribution Terminals and Service Stations."

135.4(4) *Repairs allowed.* Owners and operators of UST systems must ensure that repairs will prevent releases due to structural failure or corrosion as long as the UST system is used to store regulated substances. The repairs must meet the following requirements:

a. Repairs to UST systems must be properly conducted in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

NOTE: The following codes and standards may be used to comply with 135.4(4)*"a"*: National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; American Petroleum Institute Publication 2200, "Repairing Crude Oil, Liquified Petroleum Gas, and Product Pipelines";

American Petroleum Institute Publication 1631, "Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks"; and National Leak Prevention Association Standard 631, "Spill Prevention, Minimum 10 Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection."

b. Repairs to fiberglass-reinforced plastic tanks may be made by the manufacturer's authorized representatives or in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

c. Metal pipe sections and fittings that have released product as a result of corrosion or other damage must be replaced. Fiberglass pipes and fittings may be repaired in accordance with the manufacturer's specifications.

d. Repaired tanks and piping must be tightness tested in accordance with 135.5(4)*"c"* and 135.5(5)*"b"* within 30 days following the date of the completion of the repair except as provided in subparagraphs (1) to (3) below:

(1) The repaired tank is internally inspected in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory; or

(2) The repaired portion of the UST system is monitored monthly for releases in accordance with a method specified in 135.5(4)*"d"* through *"h"*; or

(3) Another test method is used that is determined by the department to be no less protective of human health and the environment than those listed above.

e. Within six months following the repair of any cathodically protected UST system, the cathodic protection system must be tested in accordance with 135.4(2)*"b"* and *"c"* to ensure that it is operating properly.

f. UST system owners and operators must maintain records of each repair for the remaining operating life of the UST system that demonstrate compliance with the requirements of this subrule.

135.4(5) *Reporting and record keeping.* Owners and operators of UST systems must cooperate fully with inspections, monitoring and testing conducted by the department, as well as requests for document submission, testing, and monitoring by the owner or operator pursuant to Section 9005 of Subtitle I of the Resource Conservation and Recovery Act, as amended.

a. Reporting. Owners and operators must submit the following information to the department:

(1) Notification for all UST systems (135.3(3)), which includes certification of installation for new UST systems (135.3(1)*"e"*);

(2) Reports of all releases including suspected releases (135.6(1)), spills and overfills (135.6(4)), and confirmed releases (135.7(2));

(3) Corrective actions planned or taken including initial abatement measures (135.7(3)), initial site characterization (135.9(455B)), free product removal (135.7(5)), investigation of soil and groundwater cleanup and corrective action plan (135.8(455B) to 135.12(455B)); and

(4) A notification before permanent closure or change-in-service (135.15(2)).

b. Record keeping. Owners and operators must maintain the following information:

(1) A corrosion expert's analysis of site corrosion potential if corrosion protection equipment is not used (135.3(1)*"a"*(4); (135.3(1)*"b"*(3)).

(2) Documentation of operation of corrosion protection equipment (135.4(2));

(3) Documentation of UST system repairs (135.4(4)*"f"*);

(4) Recent compliance with release detection requirements (135.5(6)); and

(5) Results of the site investigation conducted at permanent closure (135.15(5)).

c. Availability and maintenance of records. Owners and operators must keep the records required either:

(1) At the UST site and immediately available for inspection by the department; or

(2) At a readily available alternative site and be provided for inspection to the department upon request.

NOTE: In the case of permanent closure records required under 135.15(5), owners and operators are also provided with the additional alternative of mailing closure records to the department if they cannot be kept at the site or an alternative site as indicated above.

135.4(6) *Training required for UST operators.*

a. An owner or operator shall designate Class A, Class B, and Class C operators for each underground storage tank system or facility that has underground storage tanks regulated by the department, except for unstaffed facilities, which may designate only Class A and Class B operators.

b. A facility may not operate after December 31, 2011, unless operators have been designated and trained as required in this rule, or unless otherwise agreed upon by the department based on a finding of good cause for failure to meet this requirement and a plan for designation and training at the earliest practicable date.

c. Trained operators must be readily available to respond to suspected or confirmed releases, equipment shut-offs or failures, and other unusual operating conditions.

d. A Class A or Class B operator should be immediately available for telephone consultation with the Class C operator when a facility is in operation. Class A or Class B operators should be able to be on site at the storage tank facility within four hours.

e. For staffed facilities, a Class C operator must be on site whenever the UST facility is in operation.

f. For unstaffed facilities, a Class B operator must be geographically located such that the person can be on site within two hours of being contacted by the public, the owner or operator of the facility, or the department. Emergency contact information and emergency procedures must be prominently displayed at the site. An unstaffed facility shall have an emergency shutoff device as provided in 135.5(1) and a sign posted in a conspicuous place that includes the name and telephone number of the facility owner, an emergency response telephone number to contact the Class B operator, and information on local emergency responders.

g. Designated operators must successfully complete required training under subrule 135.4(9) no later than December 31, 2011.

h. A person may be designated for more than one class of operator.

i. When a facility is found to be out of compliance, the department may require the owner and operator to retrain the designated UST system Class A, B, or C operator under a plan approved by the department. The retraining must occur within 60 days from departmental notice for Class A and Class B operators and within 15 days for Class C operators.

135.4(7) *UST operator responsibilities.*

a. Class A operator.

(1) Class A operators have the primary responsibility to operate and maintain the underground storage tank system and facility. The Class A operator's responsibilities include managing resources and personnel to achieve and maintain compliance with regulatory requirements under this chapter in the following ways:

1. Class A operators assist the owner by ensuring that underground storage tank systems are properly installed and expeditiously repaired and inspected; financial responsibility is maintained; and records of system installation, modification, inspection and repair are retained and made available to the department and licensed compliance inspectors. The Class A operator shall properly respond to and report emergencies caused by releases or spills from UST systems, ensure that the annual tank management fees are paid, and ensure that Class B and Class C operators are properly trained.

2. Class A operators shall be familiar with training requirements for each class of operator and may provide required training for Class C operators.

3. Class A operators shall provide site drawings that indicate equipment locations for Class B and Class C operators.

(2) Department-licensed installers, installation inspectors, and compliance inspectors may perform Class A operator duties when employed or contracted by the tank owner to perform these functions so long as they are properly trained and designated as Class A operators pursuant to subrules 135.4(9) through 135.4(11). Class A operators who are also licensed compliance inspectors under 567—Chapter 134, Part C, may perform in-house facility inspections of the UST system, but shall not perform department-mandated compliance inspections pursuant to rule 567—135.20(455B). Compliance

inspections of a UST facility required by rule 567—135.20(455B) must be completed by a third-party compliance inspector licensed under 567—Chapter 134, Part B.

(3) When there is a change in ownership or operator status, the new owner or operator is responsible for designating a Class A operator prior to bringing the UST system into operation. The Class A operator is responsible for ensuring that all necessary documentation for change of ownership is completed and submitted to the department and that all compliance requirements of this chapter are satisfied prior to bringing the UST system into operation. The compliance requirements may be provided to the owner or operator using the department's checklist.

If the UST system was temporarily closed, the designated Class A operator must ensure the department's checklist for returning a UST into service is followed, all compliance requirements of this chapter have been met, and the necessary documentation is submitted to the department.

(4) When there is a change in UST ownership, property ownership or operator status, the designated Class A operator for the current owner and operator is responsible for notifying the department when the change is final and, if possible, prior to the new owner or operator taking possession of the site.

b. Class B operator.

(1) A Class B operator implements applicable underground storage tank regulatory requirements and standards in the field or at the tank facility. A Class B operator oversees and implements the day-to-day aspects of operation, maintenance, and record keeping for the underground storage tanks at facilities within four hours of travel time from the Class B operator's principal place of business. A Class B operator's responsibilities include, but are not limited to:

1. Performing mandated system tests at required intervals and making sure spill prevention, overfill control equipment, and corrosion protection equipment are properly functioning.
2. Assisting the owner by ensuring that release detection equipment is operational, release detection monitoring and tests are performed at the proper intervals, and release detection records are retained and made available to the department and compliance inspectors.
3. Making sure record-keeping and reporting requirements are met and that relevant equipment manufacturers' or third-party performance standards are available and followed.
4. Properly responding to, investigating, and reporting emergencies caused by releases or spills from USTs.
5. Performing UST release detection in accordance with rule 567—135.5(455B).
6. Monitoring the status of UST release detection.
7. Meeting spill prevention, overfill prevention, and corrosion protection requirements.
8. Reporting suspected and confirmed releases and taking release prevention and response actions according to the requirements of rule 567—135.6(455B).
9. Training and documenting Class C operators to make sure at least one Class C operator is on site during operating hours. Class B operators shall be familiar with Class C operator responsibilities and may provide required training for Class C operators.

(2) Department-licensed installers, installation inspectors, and compliance inspectors may perform Class B operator duties when employed or contracted by the tank owner to perform these functions so long as they are properly trained and designated as Class B operators under subrules 135.4(9) through 135.4(11). Class B operators who are also licensed compliance inspectors under 567—Chapter 134, Part C, may perform in-house facility inspections of the UST system, but cannot perform department-mandated compliance inspections pursuant to rule 567—135.20(455B). Compliance inspections of a UST facility pursuant to rule 567—135.20(455B) must be completed by a third-party compliance inspector licensed under 567—Chapter 134, Part B.

(3) The owner or operator of a site undergoing a change in ownership shall designate a Class B operator prior to bringing the UST system into operation. The Class B operator must conduct an inspection using the department's inspection checklist and submit the completed checklist along with the change of ownership form prior to operation. If a UST system was temporarily closed, the Class B operator shall ensure that the department's checklist for returning a UST to service is followed and that the necessary documentation is submitted to the department prior to operation of the UST system.

c. Class C operator. A Class C operator is an on-site employee who typically controls or monitors the dispensing or sale of regulated substances and is the first to respond to events indicating emergency conditions. A Class C operator must be present at the facility at all times during normal operating hours. A Class C operator monitors product transfer operations to ensure that spills and overfills do not occur. The Class C operator must know how to properly respond to spills, overfills and alarms when they do occur. In the event of a spill, overfill or alarm, a Class C operator shall notify the Class A and Class B operators, as well as the department and appropriate local emergency authorities as required by rule.

(1) Within six months after October 14, 2009, written basic operating instructions, emergency contact names and telephone numbers, and basic procedures specific to the facility shall be provided to all Class C operators and readily available on site.

(2) There may be more than one Class C operator at a storage tank facility, but not all employees of a facility need be Class C operators.

135.4(8) *UST operator training course requirements.* Individuals must attend a department-approved training course covering material designated for each operator class. Individuals must attend every session of the training, take the examination, and attend examination review.

a. Class A operators. To be certified as a Class A operator, the applicant must successfully complete a department-approved training course that covers underground storage tank system requirements as outlined in 567—Chapters 134 to 136. The course must also provide a general overview of the department's UST program, purpose, groundwater protection goals, public safety and administrative requirements. The training must include, but is not limited to, the following:

(1) Components and materials of underground storage tank systems.

(2) A general discussion of the content of PEI/RP900-08, Recommended Practices for the Inspection and Maintenance of UST Systems, and PEI/RP500, Recommended Practices for Inspection and Maintenance of Motor Fuel Dispensing Equipment.

(3) Spill and overfill prevention, to include the American Petroleum Institute (API) Publication RP1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," and National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code."

(4) Ensuring product delivery to the correct tank by using color-symbol codes in the API Standard RP1637, "Using the API Color-Symbol System to Mark Equipment and Vehicles for Product Identification at Service Stations and Distribution Terminals."

(5) Proper fuel ordering and delivery, including procedures in API RP1007, "Loading and Unloading of MC/DOT 406 Cargo Tank Motor Vehicles."

(6) Release detection methods and related reporting requirements.

(7) Corrosion protection and inspection requirements, including the requirement to have a department-licensed cathodic protection tester.

(8) Discussion of the benefits of monthly or frequent inspections and content and use of inspection checklists. Training materials for operators shall include the department's "Iowa UST Operator Inspection Checklist" or a checklist template similar to the department's document.

(9) Requirement and content of third-party compliance inspections.

(10) How to properly respond to an emergency, including hazardous conditions.

(11) Product and equipment compatibility, including the department's ethanol compatibility guidance and certification.

(12) Financial responsibility, including detailed explanation of liability, notice and claim procedures, and the six-month window to check for and report a release prior to insurance termination to maintain coverage for corrective action.

(13) Notification of installation and storage tank registration requirements.

(14) Requirement to use department-licensed companies and individuals for UST installation, testing, lining, and removal.

(15) Temporary and permanent closure procedures and requirements.

(16) NESHAP vapor recovery requirements.

(17) Conditions under which the department may stop fuel delivery and take enforcement action.

(18) Ensuring that annual tank management fees are paid.

(19) Ensuring that suspected and confirmed releases are investigated and reported according to subrule 135.6(1).

b. Class B operators. To be certified as a Class B operator, the individual must successfully complete a department-approved training course that provides in-depth understanding of UST system regulations applicable to this class. Training must also provide a general overview of the department's UST program, purpose, groundwater protection goals, public safety and administrative requirements. Training shall cover the operation and maintenance requirements set forth in this chapter, including, but not limited to, the following:

(1) A general discussion of the content of PEI/RP900-08, Recommended Practices for the Inspection and Maintenance of UST Systems, and PEI/RP500, Recommended Practices for Inspection and Maintenance of Motor Fuel Dispensing Equipment.

(2) Components and materials of underground storage tank systems.

(3) Spill and overfill prevention.

(4) Ensuring product delivery to the correct tank by using color-symbol codes in the API Standard RP1637.

(5) Proper fuel ordering and delivery, including procedures from API RP1007.

(6) Methods of release detection and related reporting requirements.

(7) Corrosion protection and related testing.

(8) Discussion of the benefits of monthly or frequent inspections and content and use of inspection checklists. Training materials for operators shall include the department's "Iowa UST Operator Inspection Checklist" or a checklist template similar to the department's document.

(9) Requirement and content of third-party compliance inspections.

(10) Emergency response, reporting and investigating releases.

(11) Product and equipment compatibility, including the department's ethanol compatibility guidance and certification.

(12) Financial responsibility, including detailed explanation of liability, notice and claim procedures, and the six-month window to check for and report a release prior to insurance termination to maintain coverage for corrective action.

(13) Notification of installation and storage tank registration requirements.

(14) Requirement to use department-licensed companies and individuals for UST installation, testing, lining, and removal.

(15) Reporting and record-keeping requirements.

(16) Overview of Class C operator training requirements.

(17) NESHAP vapor recovery requirements.

(18) Conditions under which the department may stop fuel delivery and take enforcement action.

c. Class C operators. To be certified as a Class C operator, an individual must complete a department-approved training course that covers, at a minimum, a general overview of the department's UST program and purpose; groundwater protection goals; public safety and administrative requirements; and action to be taken in response to an emergency condition due to a spill or release from a UST system. Training must include written procedures for the Class C operator, including notification instructions necessary in the event of emergency conditions. The written instructions and procedures must be readily available on site. A Class A or Class B operator may provide Class C training.

135.4(9) *Examination and review requirement.* Class A and Class B operators must complete the department-approved training course and take an examination to verify their understanding and knowledge. The examination may include both written and practical (hands-on) testing activities. The trainer must follow up the examination with a review of missed test questions with the class or individual to ensure understanding of problem areas. Upon successful completion of the training course, the applicant will receive a certificate verifying the applicant's status as a Class A, Class B, or Class C operator.

a. Reciprocity. The department may waive the training course for operators upon a showing of successful completion of a training course and examination approved by another state or regulatory

agency that the department determines are substantially equivalent to the UST requirements contained in this chapter.

b. Transferability to another UST site. Class A and Class B operators may transfer to other UST facilities in Iowa provided the operator is properly designated by the facility owner as a Class A or Class B operator according to 567—subrule 134.4(13). Class A and Class B operators transferring from other states shall seek prior approval of training qualifications, unless the department has preapproved the out-of-state program as substantially equivalent to the requirements of this chapter.

135.4(10) *Timing of UST operator training.*

a. An owner shall ensure that Class A, Class B, and Class C operators are trained as soon as practicable after October 14, 2009, contingent upon availability of approved training providers, but not later than December 31, 2011, except as provided in paragraph 135.4(6)*"b."*

b. When a Class A or Class B operator is replaced, a new operator must be trained prior to assuming duties for that class of operator.

c. Class C operators must be trained before assuming the duties of a Class C operator. Within six months after October 14, 2009, written basic operating instructions, emergency contact names and telephone numbers, and basic procedures specific to the facility shall be provided to all Class C operators and readily available on site. A Class C operator may be briefed on these procedures concurrent with annual safety training required under Occupational Safety and Health Administration regulations, 29 CFR, Part 1910.

135.4(11) *Documentation of operator training.*

a. The owner of an underground storage tank facility shall maintain a list of designated operators. The list shall be made available to the department in accordance with subrule 135.4(5). The list shall represent the current Class A, Class B and Class C operators for the UST facility and must include:

(1) The name of each operator and the operator's class(es); contact information for Class A and Class B operators; the date each operator successfully completed initial training and refresher training, if any; the name of the company providing the training; and the name of the trainer.

(2) For all classes of operators, the site(s) for which an operator is responsible if more than one site.

b. A copy of the certificates of training for Class A and Class B operators shall be on file and readily available for inspection in accordance with subrule 135.4(5).

c. A copy of the certificates of training for Class B and Class C operators shall be available at each facility for which the operator is responsible.

d. Class A and Class B operator contact information, including names and telephone numbers and any emergency information, shall be conspicuously posted at unstaffed facilities near the dispensers and the station building.

[**ARC 8124B**, IAB 9/9/09, effective 10/14/09]

567—135.5(455B) Release detection.

135.5(1) *General requirements for all UST systems.*

a. Owners and operators of new and existing UST systems must provide a method, or combination of methods, of release detection that:

(1) Can detect a release from any portion of the tank and the connected underground piping that routinely contains product;

(2) Is installed, calibrated, operated, and maintained in accordance with the manufacturer's instructions, including routine maintenance and service checks for operability or running condition; and

(3) Meets the performance requirements in 135.5(4) or 135.5(5), with any performance claims and their manner of determination described in writing by the equipment manufacturer or installer. In addition, methods conducted in accordance with 135.5(4)*"b," "c,"* and *"d"* and 135.5(5)*"b"* after December 22, 1990, and 135.5(5)*"a"* after September 22, 1991, except for methods permanently installed prior to those dates, must be capable of detecting the leak rate or quantity specified for that method with a probability of detection of 0.95 and a probability of false alarm of 0.05.

b. When a release detection method operated in accordance with the performance standards in 135.5(4) and 135.5(5) indicates a release may have occurred, owners and operators must notify the department in accordance with rule 135.6(455B).

c. Owners and operators of all UST systems must comply with the release detection requirements of this rule by December 22 of the year listed in the following table:

Scheduled for Phase-in of Release Detection					
Year System Was Installed	Year When Release Detection is Required (by December 22 of the Year Indicated)				
	1989	1990	1991	1992	1993
Before 1965 or Date Unknown	RD	P			
1965-1969		P/RD			
1970-1974		P	RD		
1975-1979		P		RD	
1980-1988		P			RD
New Tanks	Immediately upon installation				

P = Must begin release detection for all pressurized piping in accordance with 135.5(2)*"b"*(1).

RD = Must begin release detection for tanks and suction piping in accordance with 135.5(2)*"a,"* 135.5(2)*"b"*(2), and 135.5(3).

d. Any existing UST system that cannot apply a method of release detection that complies with the requirements of this rule must complete the closure procedures in rule 135.15(455B) by the date on which release detection is required for that UST system under paragraph *"c."*

e. **[See Objection at end of chapter]** UST systems using pressurized piping that operate with no on-site personnel shall comply with the following requirements:

(1) Whenever an in-line leak detector is installed or replaced, it must be capable of shutting down the submersible pump.

(2) Existing sites with an in-line leak detection system in place on February 17, 2010, may continue operation provided that, by January 1, 2013, either of the following UST system modifications is made:

1. An in-line leak detector capable of shutting off the submersible pump is installed; or

2. The UST system is equipped with a device that immediately alerts the Class B operator or designee when a leak is detected. The Class B operator or designee shall be on site within two hours of notification and shut down the submersible pump. The UST system cannot be returned to service until the problem that caused the release response is resolved.

3. A temporary extension of time to meet these upgrade requirements may be granted if it can be shown that there is no reasonable alternative fueling source in the vicinity or fueling is needed to satisfy emergency or public safety considerations. The request for temporary extension must include documentation and a plan for upgrading prior to January 1, 2013.

(3) At sites with secondary containment sumps and continuous automatic sump sensors for leak detection monitoring, the continuous automatic sump sensors must shut off product flow when a leak is detected. If it is determined that a malfunction of the leak detection system is the cause of the shutdown, the UST system must be immediately repaired but may continue to be operated while the repairs are made.

135.5(2) *Requirements for petroleum UST systems.* Owners and operators of petroleum UST systems must provide release detection for tanks and piping as follows:

a. Tanks. Tanks must be monitored at least every 30 days for releases using one of the methods listed in 135.5(4)*"d"* to *"h"* except that:

(1) UST systems that meet the performance standards in 135.3(1) or 135.3(2), and the monthly inventory control requirements in 135.5(4)*"a"* or *"b,"* may use tank tightness testing (conducted in

accordance with 135.5(4)*"c"*) at least every five years until December 22, 1998, or until ten years after the tank is installed or upgraded under 135.3(2)*"b,"* whichever is later;

(2) UST systems that do not meet the performance standards in 135.3(1) or 135.3(2) may use monthly inventory controls (conducted in accordance with 135.5(4)*"a"* or *"b"*) and annual tank tightness testing (conducted in accordance with 135.5(4)*"c"*) until December 22, 1998, when the tank must be upgraded under 135.3(2) or permanently closed under 135.15(2); and

(3) Tanks with capacity of 550 gallons or less may use weekly tank gauging (conducted in accordance with 135.5(4)*"b"*).

b. Piping. Underground piping that routinely contains regulated substances must be monitored for releases in a manner that meets one of the following requirements:

(1) *Pressurized piping.* Underground piping that conveys regulated substances under pressure must:

1. Be equipped with an automatic line leak detector conducted in accordance with 135.5(5)*"a"*; and

2. Have an annual line tightness test conducted in accordance with 135.5(5)*"b"* or have monthly monitoring conducted in accordance with 135.5(5)*"c."*

(2) *Suction piping.* Underground piping that conveys regulated substances under suction must either have a line tightness test conducted at least every three years and in accordance with 135.5(5)*"b,"* or use a monthly monitoring method conducted in accordance with 135.5(5)*"c."* No release detection is required for suction piping that is designed and constructed to meet the following standards:

1. The below-grade piping operates at less than atmospheric pressure;

2. The below-grade piping is sloped so that the contents of the pipe will drain back into the storage tank if the suction is released;

3. Only one check valve is included in each suction line;

4. The check valve is located directly below and as close as practical to the suction pump; and

5. A method is provided that allows compliance with "2" through "4" to be readily determined.

135.5(3) *Requirements for hazardous substance UST systems.* Owners and operators of hazardous substance UST systems must provide release detection that meets the following requirements:

a. Release detection at existing UST systems must meet the requirements for petroleum UST systems in 135.5(2). By December 22, 1998, all existing hazardous substance UST systems must meet the release detection requirements for new systems in paragraph *"b"* below.

b. Release detection at new hazardous substance UST systems must meet the following requirements:

(1) Secondary containment systems must be designed, constructed and installed to:

1. Contain regulated substances released from the tank system until they are detected and removed;

2. Prevent the release of regulated substances to the environment at any time during the operational life of the UST system; and

3. Be checked for evidence of a release at least every 30 days.

NOTE: The provisions of 40 CFR 265.193, Containment and Detection of Releases, as of September 13, 1988, may be used to comply with these requirements.

(2) Double-walled tanks must be designed, constructed, and installed to:

1. Contain a release from any portion of the inner tank within the outer wall; and

2. Detect the failure of the inner wall.

(3) External liners (including vaults) must be designed, constructed, and installed to:

1. Contain 100 percent of the capacity of the largest tank within its boundary;

2. Prevent the interference of precipitation or groundwater intrusion with the ability to contain or detect a release of regulated substances; and

3. Surround the tank completely (i.e., it is capable of preventing lateral as well as vertical migration of regulated substances).

(4) Underground piping must be equipped with secondary containment that satisfies the requirements of 135.5(3)*"b"*(1) above (e.g., trench liners, jacketing of double-walled pipe). In addition,

underground piping that conveys regulated substances under pressure must be equipped with an automatic line leak detector in accordance with 135.5(5)*"a"*;

(5) Other methods of release detection may be used if owners and operators:

1. Demonstrate to the department that an alternate method can detect a release of the stored substance as effectively as any of the methods allowed in 135.5(4)*"b"* to *"h"* can detect a release of petroleum;

2. Provide information to the department on effective corrective action technologies, health risks, and chemical and physical properties of the stored substance, and the characteristics of the UST site; and

3. Obtain approval from the department to use the alternate release detection method before the installation and operation of the new UST system.

135.5(4) *Methods of release detection for tanks.* Each method of release detection for tanks used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Inventory control. Product inventory control (or another test of equivalent performance) must be conducted monthly to detect a release of at least 1.0 percent of flow-through plus 130 gallons on a monthly basis in the following manner:

(1) Inventory volume measurements for regulated substance inputs, withdrawals, and the amount still remaining in the tank are recorded each operating day;

(2) The equipment used is capable of measuring the level of product over the full range of the tank's height to the nearest 1/8 of an inch;

(3) The regulated substance inputs are reconciled with delivery receipts by measurement of the tank inventory volume before and after delivery;

(4) Deliveries are made through a drop tube that extends to within 1 foot of the tank bottom;

(5) Product dispensing is metered and recorded within the local standards for meter calibration or an accuracy of 6 cubic inches for every 5 gallons of product withdrawn; and

(6) The measurement of any water level in the bottom of the tank is made to the nearest 1/8 of an inch at least once a month.

NOTE: Practices described in the American Petroleum Institute Publication 1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," may be used, where applicable, as guidance in meeting the requirements of subrule 135.5(4), paragraph *"a,"* subparagraphs (1) to (6).

b. Manual tank gauging. Manual tank gauging must meet the following requirements:

(1) Tank liquid level measurements are taken at the beginning and ending of a period of at least 36 hours during which no liquid is added to or removed from the tank;

(2) Level measurements are based on an average of two consecutive stick readings at both the beginning and ending of the period;

(3) The equipment used is capable of measuring the level of product over the full range of the tank's height to the nearest 1/8 of an inch;

(4) A leak is suspected and subject to the requirements of rule 135.6(455B) if the variation between beginning and ending measurements exceeds the weekly or monthly standards in the following table:

Nominal Tank Capacity	Weekly Standard (one test)	Monthly Standard (average of four tests)
550 gallons or less	10 gallons	5 gallons
551-1,000 gallons	13 gallons	7 gallons
1,001-2,000 gallons	26 gallons	13 gallons

(5) Only tanks of 550 gallons or less nominal capacity may use this as the sole method of release detection. Tanks of 551 to 2000 gallons may use the method in place of manual inventory control in 135.5(4)*"a."* Tanks of greater than 2000 gallons nominal capacity may not use this method to meet the requirements of this rule.

c. Tank tightness testing. Tank tightness testing (or another test of equivalent performance) must be capable of detecting a 0.1 gallon-per-hour leak rate from any portion of the tank that routinely

contains product while accounting for the effects of thermal expansion or contraction of the product, vapor pockets, tank deformation, evaporation or condensation, and the location of the water table.

d. Automatic tank gauging. Equipment for automatic tank gauging that tests for the loss of product and conducts inventory control must meet the following requirements:

(1) The automatic product level monitor test can detect a 0.2 gallon-per-hour leak rate from any portion of the tank that routinely contains product; and

(2) Inventory control (or another test of equivalent performance) is conducted in accordance with the requirements of 135.5(4)*"a."*

e. Vapor monitoring. Testing or monitoring for vapors within the soil gas of the excavation zone must meet the following requirements:

(1) The materials used as backfill are sufficiently porous (e.g., gravel, sand, crushed rock) to readily allow diffusion of vapors from releases into the excavation area;

(2) The stored regulated substance, or a tracer compound placed in the tank system, is sufficiently volatile (e.g., gasoline) to result in a vapor level that is detectable by the monitoring devices located in the excavation zone in the event of a release from the tank;

(3) The measurement of vapors by the monitoring device is not rendered inoperative by the groundwater, rainfall, or soil moisture or other known interferences so that a release could go undetected for more than 30 days;

(4) The level of background contamination in the excavation zone will not interfere with the method used to detect releases from the tank;

(5) The vapor monitors are designed and operated to detect any significant increase in concentration above background of the regulated substance stored in the tank system, a component or components of that substance, or a tracer compound placed in the tank system;

(6) In the UST excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4)*"e"*(1) to (4) and to establish the number and positioning of monitoring wells that will detect releases within the excavation zone from any portion of the tank that routinely contains product; and

(7) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

f. Groundwater monitoring. Testing or monitoring for liquids on the groundwater must meet the following requirements:

(1) The regulated substance stored is immiscible in water and has a specific gravity of less than 1;

(2) Groundwater is never more than 20 feet from the ground surface and the hydraulic conductivity of the soil(s) between the UST system and the monitoring wells or devices is not less than 0.01 cm/sec (e.g., the soil should consist of gravels, coarse to medium sands, coarse silts or other permeable materials);

(3) The slotted portion of the monitoring well casing must be designed to prevent migration of natural soils or filter pack into the well and to allow entry of regulated substance on the water table into the well under both high and low groundwater conditions;

(4) Monitoring wells shall be sealed from the ground surface to the top of the filter pack;

(5) Monitoring wells or devices intercept the excavation zone or are as close to it as is technically feasible;

(6) The continuous monitoring devices or manual methods used can detect the presence of at least 1/8 of an inch of free product on top of the groundwater in the monitoring wells;

(7) Within and immediately below the UST system excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4)*"f"*(1) to (5) and to establish the number and positioning of monitoring wells or devices that will detect releases from any portion of the tank that routinely contains product; and

(8) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

g. Interstitial monitoring. Interstitial monitoring between the UST system and a secondary barrier immediately around or beneath it may be used, but only if the system is designed, constructed and installed to detect a leak from any portion of the tank that routinely contains product and also meets one of the following requirements:

(1) For secondary containment systems, the sampling or testing method must be able to detect a release through the inner wall in any portion of the tank that routinely contains product:

1. Continuously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space; or

2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space.

3. The interstitial space shall be maintained and kept free of liquid, debris or anything that could interfere with leak detection capabilities.

NOTE: The provisions outlined in the Steel Tank Institute's "Standard for Dual Wall Underground Storage Tanks" may be used as guidance for aspects of the design and construction of underground steel double-walled tanks.

(2) For UST systems with a secondary barrier within the excavation zone, the sampling or testing method used can detect a release between the UST system and the secondary barrier:

1. The secondary barrier around or beneath the UST system consists of artificially constructed material that is sufficiently thick and impermeable (at least 10^{-6} cm/sec for the regulated substance stored) to direct a release to the monitoring point and permit its detection;

2. The barrier is compatible with the regulated substance stored so that a release from the UST system will not cause a deterioration of the barrier allowing a release to pass through undetected;

3. For cathodically protected tanks, the secondary barrier must be installed so that it does not interfere with the proper operation of the cathodic protection system;

4. The groundwater, soil moisture, or rainfall will not render the testing or sampling method used inoperative so that a release could go undetected for more than 30 days;

5. The site is assessed to ensure that the secondary barrier is always above the groundwater and not in a 25-year flood plain, unless the barrier and monitoring designs are for use under such conditions; and

6. Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

(3) For tanks with an internally fitted liner, an automated device can detect a release between the inner wall of the tank and the liner, and the liner is compatible with the substance stored.

h. Other methods. Any other type of release detection method, or combination of methods, can be used if:

(1) It can detect a 0.2 gallon-per-hour leak rate or a release of 150 gallons within a month with a probability of detection of 0.95 and a probability of false alarm of 0.05; or

(2) The department may approve another method if the owner and operator can demonstrate that the method can detect a release as effectively as any of the methods allowed in paragraphs *"c"* to *"h."* In comparing methods, the department shall consider the size of release that the method can detect and the frequency and reliability with which it can be detected. If the method is approved, the owner and operator must comply with any conditions imposed by the department on its use to ensure the protection of human health and the environment.

135.5(5) *Methods of release detection for piping.* Each method of release detection for piping used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Automatic line leak detectors. Methods which alert the operator to the presence of a leak by restricting or shutting off the flow of regulated substances through piping or triggering an audible or visual alarm may be used only if they detect leaks of 3 gallons per hour at 10 pounds per square inch line pressure within one hour. An annual test of the operation of the leak detector must be conducted in accordance with the manufacturer's requirements.

b. Line tightness testing. A periodic test of piping may be conducted only if it can detect a 0.1 gallon-per-hour leak rate at one and one-half times the operating pressure.

c. Applicable tank methods. Any of the methods in 135.5(4)*"e"* through *"h"* may be used if they are designed to detect a release from any portion of the underground piping that routinely contains regulated substances.

d. Interstitial monitoring of secondary containment. Interstitial monitoring may be used for any piping with secondary containment designed for and capable of interstitial monitoring.

(1) Leak detection shall be conducted:

1. Continously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space or containment sump; or

2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space or containment sump, such as visual inspection.

(2) The interstitial space or sump shall be maintained and kept free of water, debris or anything that could interfere with leak detection capabilities.

(3) At least every two years, any sump shall be visually inspected for integrity of sides and floor and tightness of piping penetration seals. Any automatic sensing device shall be tested for proper function.

135.5(6) *Release detection record keeping.* All UST system owners and operators must maintain records in accordance with 135.4(5) demonstrating compliance with all applicable requirements of this rule. These records must include the following:

a. All written performance claims pertaining to any release detection system used, and the manner in which these claims have been justified or tested by the equipment manufacturer or installer, must be maintained for five years, or for another reasonable period of time determined by the department, from the date of installation;

b. The results of any sampling, testing, or monitoring must be maintained for at least one year, or for another reasonable period of time determined by the department, except that the results of tank tightness testing conducted in accordance with 135.5(4)*"c"* must be retained until the next test is conducted; and

c. Written documentation of all calibration, maintenance, and repair of release detection equipment permanently located on-site must be maintained for at least one year after the servicing work is completed, or for another reasonable time period determined by the department. Any schedules of required calibration and maintenance provided by the release detection equipment manufacturer must be retained for five years from the date of installation.

[**ARC 8469B**, IAB 1/13/10, effective 2/17/10 (See Delay note at end of chapter)]

567—135.6(455B) Release reporting, investigation, and confirmation.

135.6(1) *Reporting of suspected releases.* Owners and operators of UST systems must report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in 567—131.1(455B), or another reasonable time period specified by the department, and follow the procedures in 135.8(1) for any of the following conditions:

a. The discovery by owners and operators or others of released regulated substances at the UST site or in the surrounding area (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface water);

b. Unusual operating conditions observed by owners and operators (such as the erratic behavior of product dispensing equipment, the sudden loss of product from the UST system, or an unexplained presence of water in the tank), unless system equipment is found to be defective but not leaking, and is immediately repaired or replaced; and

c. Monitoring results from a release detection method required under 135.5(2) and 135.5(3) that indicate a release may have occurred unless:

(1) The monitoring device is found to be defective, and is immediately repaired, recalibrated or replaced, and additional monitoring does not confirm the initial result; or

(2) In the case of inventory control, a second month of data does not confirm the initial result.

135.6(2) *Investigation due to off-site impacts.* When required by the department, owners and operators of UST systems must follow the procedures in 135.6(3) to determine if the UST system is the source of off-site impacts. These impacts include the discovery of regulated substances (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface and drinking waters) that has been observed by the department or brought to its attention by another party.

135.6(3) *Release investigation and confirmation steps.* Owners and operators must immediately investigate and confirm all suspected releases of regulated substances requiring reporting under 135.6(1)

within seven days, or another reasonable time period specified by the department, using either the following steps or another procedure approved by the department:

a. System test. Owners and operators must conduct tests (according to the requirements for tightness testing in 135.5(4)*"c"* and 135.5(5)*"b"*) that determine whether a leak exists in that portion of the tank that routinely contains product, or the attached delivery piping or both.

(1) Owners and operators must repair, replace or upgrade the UST system and begin corrective action in accordance with rule 135.9(455B) if the test results for the system, tank, or delivery piping indicate a leak exists.

(2) Further investigation is not required if the test results for the system, tank, and delivery piping do not indicate a leak exists and if environmental contamination is not the basis for suspecting a release.

(3) Owners and operators must conduct a site check as described in paragraph *"b"* of this subrule if the test results for the system, tank, and delivery piping do not indicate a leak exists but environmental contamination is the basis for suspecting a release.

b. Site check. A certified groundwater professional must conduct a site check in accordance with the tank closure in place procedures as provided in 135.15(3) or they may conduct a Tier 1 assessment in accordance with subrule 135.9(3). Under either procedure, the certified groundwater professional must follow the policies and procedures applicable to sites where bedrock is encountered before groundwater as provided in 135.8(5) to avoid creating a preferential pathway for soil or groundwater contamination to reach a bedrock aquifer. The certified groundwater professional must measure for the presence of a release where contamination is most likely to be present at the UST site. In selecting sample types, sample locations, and measurement methods, the certified groundwater professional must consider the nature of the stored substance, the type of initial alarm or cause for suspicion, the type of backfill, the depth of groundwater, and other factors appropriate for identifying the presence and source of the release.

(1) If the test results of the site check indicate action levels in 135.14(455B) have been exceeded, owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

(2) If the test results for the excavation zone or the UST site do not indicate a release has occurred, further investigation is not required.

135.6(4) *Reporting and cleanup of spills and overfills.*

a. Reportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release, and report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in rule 567—131.1(455B) and begin corrective action in accordance with rules 135.7(455B) to 135.12(455B) in the following cases:

(1) Spill, overfill or any aboveground release of petroleum that results in a release to the environment that exceeds 25 gallons, causes a sheen on nearby surface water, impacts adjacent property, or contaminates groundwater; and

(2) Spill, overfill or any aboveground release of a hazardous substance that results in a release to the environment that equals or exceeds its reportable quantity under CERCLA (40 CFR 302) as of September 13, 1988.

b. Nonreportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release of petroleum that is less than 25 gallons and a spill, overfill or any aboveground release of a hazardous substance that is less than the reportable quantity. If cleanup cannot be accomplished within 24 hours, owners and operators must immediately notify the department.

NOTE: Any spill or overfill that results in a hazardous condition as defined in rule 567—131.1(455B) must be reported within 6 hours. This includes the transporter of the product. A release of a hazardous substance equal to or in excess of its reportable quantity must also be reported immediately (rather than within 24 hours) to the National Response Center under Sections 102 and 103 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 and to appropriate state and local authorities under Title III of the Superfund Amendments and Reauthorization Act of 1986.

567—135.7(455B) Release response and corrective action for UST systems containing petroleum or hazardous substances.

135.7(1) *General.* Owners and operators of petroleum or hazardous substance UST systems must, in response to a confirmed release from the UST system, comply with the requirements of this rule except for USTs excluded under 135.1(3)*"b"* and UST systems subject to RCRA Subtitle C corrective action requirements under Section 3004(u) of the Resource Conservation and Recovery Act, as amended.

135.7(2) *Initial response.* Upon confirmation of a release in accordance with 135.6(3) or after a release from the UST system is identified in any other manner, owners and operators must perform the following initial response actions within 24 hours of a release or within another reasonable period of time specified by the department:

a. Report the release to the department (e.g., by telephone or electronic mail);

b. Take immediate action to prevent any further release of the regulated substance into the environment; and

c. Identify and mitigate fire, explosion, and vapor hazards.

135.7(3) *Initial abatement measures and site check.*

a. Unless directed to do otherwise by the department, owners and operators must perform the following abatement measures:

(1) Remove as much of the regulated substance from the UST system as is necessary to prevent further release to the environment;

(2) Visually inspect any aboveground releases or exposed below-ground releases and prevent further migration of the released substance into surrounding soils and groundwater;

(3) Continue to monitor and mitigate any additional fire and safety hazards posed by vapors or free product that have migrated from the UST excavation zone and entered into subsurface structures (such as sewers or basements);

(4) Remedy hazards posed by contaminated soils that are excavated or exposed as a result of release confirmation, site investigation, abatement, or corrective action activities. If these remedies include treatment or disposal of soils, the owner and operator must comply with applicable state and local requirements;

(5) Rescinded IAB 7/17/96, effective 8/15/96.

(6) Investigate to determine the possible presence of free product, and begin free product removal as soon as practicable and in accordance with 135.7(5).

b. Within 20 days after release confirmation, or within another reasonable period of time determined by the department, owners and operators must submit a report to the department summarizing the initial abatement steps taken under paragraph *"a"* and any resulting information or data.

135.7(4) *Initial site characterization.* Rescinded IAB 7/17/96, effective 8/15/96.

135.7(5) *Free product assessment and removal.* At sites where investigations under 135.7(3)*"a"*(6) indicate 0.01 ft. or more of free product, owners and operators must immediately initiate a free product recovery assessment and submit a report in accordance with paragraph *"d"* and initiate interim free product removal while continuing, as necessary, any actions initiated under 135.7(2) to 135.7(4), or preparing for actions required under 135.8(455B) to 135.12(455B). Owners and operators must immediately begin interim free product removal by bailing or by installation and maintenance of passive skimming equipment until an alternative removal method is required by or approved by the department. A certified groundwater professional must initially determine the frequency of bailing and proper installation and maintenance of the skimming equipment based on a determination of the recharge rate of the free product. The department may approve implementation of this interim removal process by persons not certified as groundwater professionals. For approval a certified groundwater professional must submit (1) sufficient documentation establishing that the bailing or skimming system has been adequately designed and tested, and (2) a written plan for regular maintenance, reporting and supervision by a certified groundwater professional. Interim free product recovery reports must be submitted to the department on a monthly basis and on forms provided by the department. In meeting the requirements of this subrule, owners and operators must:

a. Conduct free product removal at a frequency determined by the recharge rate of the product and in a manner that minimizes the spread of contamination into previously uncontaminated zones by using recovery and disposal techniques appropriate to the hydrogeologic conditions at the site, and that properly treats, discharges or disposes of recovery by-products in compliance with applicable local, state and federal regulations. Unless approved by the department, free product assessment and recovery activities must be conducted by a certified groundwater professional. Owners and operators must report the results of free product removal activities on forms designated by the department;

b. Use abatement of free product migration as a minimum objective for the design of the free product removal system. Free product recovery systems must be designed to remove free product to the maximum extent practicable;

c. Handle any flammable products in a safe and competent manner to prevent fires or explosions; and

d. Free product recovery assessment and report. Unless directed to do otherwise by the department, prepare and submit to the department, within 45 days after confirming a release, a free product recovery assessment report and a proposal for subsequent free product removal activities. The free product recovery assessment report and removal proposal must contain at least the following information:

(1) The name of the person(s) responsible for implementing the free product removal measures;

(2) The estimated quantity, type and thickness of free product observed or measured in monitoring wells, boreholes, and excavations, the recharge rate in all affected monitoring wells and a detailed description of the procedures used to determine the recharge rate;

(3) A detailed justification for the free product removal technology proposed for the site. Base the justification narrative on professional judgment considering the characteristics of the free product plume (i.e., estimated volume, type of product, thickness, extent), an assessment of cost effectiveness based on recovery costs compared to alternative methods, site hydrology and geology, when the release event occurred, testing conducted to verify design assumptions and the potential for petroleum vapors or explosive conditions to occur in enclosed spaces. Proposals for removal systems other than hand bailing or passive skimming systems must be completed and submitted on a format consistent with the department's corrective action design report.

(4) A schematic and narrative description of the free product recovery system used;

(5) Whether any discharge will take place on site or off site during the recovery operation and where this discharge will be located;

(6) A schematic and narrative description of the treatment system, and the effluent quality expected from any discharge;

(7) The steps that have been or are being taken to obtain necessary permits for any discharge;

(8) The disposition of the recovered free product;

(9) Free product plume definition and map. The extent of free product in groundwater must be assessed. The number and location of wells and separation distance between the wells used to define the free product plume must be based on the receptors present and the site hydrology and geology. A minimum of five monitoring wells are required to construct the plume map. If the groundwater professional can adequately define the plume using other technology as specified in department guidance, fewer than five wells may be used. The boundary of the plume may be determined by linear interpolation consistent with the methods described in 135.10(2)*"f"*(3); and

(10) The estimated volume of free product present, how the volume was calculated, recoverable volume and estimated recovery time.

e. The department will review the free product assessment report; and, if approved, the owner or operator must implement the installation of the approved recovery system within 60 days or other time period approved by the department.

f. Termination of free product recovery activities. Owners and operators may propose to the department to terminate free product recovery activities when significant amounts of hydrocarbons are not being recovered. The department will consider proposals to terminate free product recovery when the amount of product collected from a monitoring well is equal to or less than 0.1 gallon each month

for a year unless another plan is approved by the department. When free product activities have been terminated, owners and operators must inspect the monitoring wells monthly for at least a year. The department must be notified and free product recovery activities reinitiated if during the monthly well inspections it is determined the product thickness in a monitoring well exceeds 0.02 foot. The monthly well inspection records must be kept available for review by the department.

g. Unless directed to do otherwise by the department, prepare and submit to the department within 180 days after confirming a release, a Tier 2 site cleanup report.

567—135.8(455B) Risk-based corrective action.

135.8(1) *General.* The objective of risk-based corrective action is to effectively evaluate the risks posed by contamination to human health, safety and the environment using a progressively more site-specific, three-tiered approach to site assessment and data analysis. Based on the tiered assessment, a corrective action response is determined sufficient to remove or minimize risks to acceptable levels. Corrective action response includes a broad range of options including reduction of contaminant concentrations through active or passive methods, monitoring of contamination, use of technological controls or institutional controls.

a. Tier 1. The purpose of a Tier 1 assessment is to identify sites which do not pose an unreasonable risk to public health and safety or the environment based on limited site data. The objective is to determine maximum concentrations of chemicals of concern at the source of a release(s) in soil and groundwater. The Tier 1 assessment assumes worst-case scenarios in which actual or potential receptors could be exposed to these chemicals at maximum concentrations through certain soil and groundwater pathways. The point of exposure is assumed to be the source showing maximum concentrations. Risk-based screening levels (Tier 1 levels) contained in the Tier 1 Look-Up Table have been derived from models which use conservative assumptions to predict exposure to actual and potential receptors. (These models and default assumptions are contained in Appendix A.) If Tier 1 levels are not exceeded for a pathway, that pathway may not require further assessment. If the maximum concentrations exceed a Tier 1 level, the options are to conduct a more extensive Tier 2 assessment, apply an institutional control, or in limited circumstances excavate contaminated soil to below Tier 1 levels. If all pathways clear the Tier 1 levels, it is possible for the site to obtain a no action required classification.

b. Tier 2. The purpose of a Tier 2 assessment is to use site-specific data to assess the risk from chemicals of concern to existing receptors and potential receptors using fate and transport models in accordance with 135.10(455B). See 135.10(2)*"a."*

c. Tier 3. Where site conditions may not be adequately addressed by Tier 2 procedures, a Tier 3 assessment may provide more accurate risk assessment. The purpose of Tier 3 is to identify reasonable exposure levels of chemicals of concern and to assess the risk of exposure to existing and potential receptors based on additional site assessment information, probabilistic evaluations, or sophisticated chemical fate and transport models in accordance with 135.11(455B).

d. Notification. Whenever the department requires a tiered site assessment and a public water supply well is within 2,500 feet of a leaking underground storage tank site, the department will notify the public water supply operator.

e. Pathway reevaluation. Prior to issuance of a no further action certificate in accordance with 135.12(10) and Iowa Code section 455B.474(1)*"h"*(3), if it is determined that the conditions for an individual pathway that has been classified as "no action required" no longer exist, or the site presents an unreasonable risk to a public water supply well and the model used to obtain the pathway clearance underpredicts the actual contaminant plume, the individual pathway shall be further assessed consistent with the risk-based corrective action provisions in rules 567—135.8(455B) through 567—135.12(455B).

135.8(2) *Certified groundwater professional.* All assessment, corrective action, data analysis and report development required under rules 135.6(455B) to 135.12(455B) must be conducted by or under the supervision of a certified groundwater professional in accordance with these rules and department guidance as specified.

135.8(3) *Chemicals of concern.* Soil and groundwater samples from releases of petroleum regulated substances must always be analyzed for the presence of benzene, ethylbenzene, toluene, and xylenes. In

addition, if the release is suspected to include any petroleum regulated substance other than gasoline or gasoline blends, or if the source of the release is unknown, the samples must be tested for the presence of Total Extractable Hydrocarbons (TEH). Appendices A and B and department Tier 2 guidance define a method for converting TEH values to a default concentration for naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene and conversion back to a representative TEH value. These default values must be used in order to apply Tier 2 modeling to these constituents in the absence of accurate laboratory analysis. At Tier 2 and Tier 3, owners and operators have the option of analyzing for these specific constituents and applying them to the specific target levels in Appendices A and B instead of using the TEH conversion method if an approved laboratory and laboratory technique are used.

135.8(4) *Boring depth for sampling.* When drilling for the placement of groundwater monitoring wells, if groundwater is encountered, drilling must continue to the maximum of 10 feet below the first encountered groundwater or to the bottom of soil contamination as estimated by field screening. If groundwater is not encountered, drilling must continue to the deeper of 10 feet below the soil contamination as estimated by field screening or 75 feet from the ground surface.

135.8(5) *Bedrock aquifer assessment.* Prior to conducting any groundwater drilling, a groundwater professional must determine if there is a potential to encounter bedrock before groundwater. These potential areas include (1) areas where karst features or outcrops exist in the vicinity and (2) areas with bedrock less than 50 feet from the surface as illustrated in Tier 1 and Tier 2 guidance. The purpose of this determination is to prevent drilling through contaminated subsurface areas thereby creating a preferential pathway to a bedrock aquifer. If the first encountered groundwater is above bedrock but near the bedrock surface or fluctuates above and below bedrock, the groundwater professional should evaluate the subsurface geology and aquifer characteristics to determine the potential for creating a preferential pathway. If it is determined that the aquifer acts like a nongranular aquifer as provided in 135.10(3)*"a"* or bedrock is encountered before groundwater, the groundwater professional must conduct a Tier 2 assessment for all pathways under 135.10(455B), including the specified bedrock procedures under 135.10(3).

If the first encountered groundwater is above bedrock with sufficient separation and aquifer characteristics to establish that it acts as a granular aquifer, site assessment may proceed under the site check procedure in 135.6(455B), the Tier 1 procedure in 135.9(455B) or the Tier 2 procedure in 135.10(455B) as would be customary regardless of the bedrock designation. However, even under this condition, drilling through bedrock should be avoided in contaminated areas.

[**ARC 7621B**, IAB 3/11/09, effective 4/15/09]

567—135.9(455B) Tier 1 site assessment policy and procedure.

135.9(1) *General.* The main objective of a Tier 1 site assessment is to reasonably determine the highest concentrations of chemicals of concern which would be associated with any suspected or confirmed release and an accurate identification of applicable receptors. In addition, the placement and depth of borings and the construction of monitoring wells must be sufficient to determine the sources of all releases, the vertical extent of contamination, an accurate description of site stratigraphy, and a reliable determination of groundwater flow direction.

a. Pathway assessment. The pathways to be evaluated at Tier 1 are the groundwater ingestion pathway, soil leaching to groundwater pathway, groundwater vapor to enclosed space pathway, soil vapor to enclosed space pathway, soil to plastic water line pathway, groundwater to plastic water line pathway and the surface water pathway. Assessment requires a determination of whether a pathway is complete, an evaluation of actual and potential receptors, a determination of whether conditions are satisfied for obtaining no further action clearance for individual pathways, or for obtaining a complete site classification of "no action required." A pathway is considered complete if a chemical of concern has a route which could be followed to reach an actual or potential receptor.

b. Pathway clearance. If field data for an individual pathway does not exceed the applicable Tier 1 levels or if a pathway is incomplete, no further action is required to evaluate the pathway unless otherwise specified in these rules. If the field data for a pathway exceeds the applicable Tier 1 level(s) in the "Iowa Tier 1 Look-up Table," the response is to conduct further assessment under Tier 2 or Tier 3 unless an

effective institutional control is approved. In limited circumstances excavation of contaminated soils may be used as an option to obtain pathway clearance. If further site assessment indicates site data exceeds an applicable Tier 1 level(s) for a previously cleared pathway or the conditions justifying a determination of pathway incompleteness change, that pathway must be reevaluated as part of a Tier 2 or Tier 3 assessment.

c. Chemical group clearance. If field data for all chemicals of concern within a designated group of chemicals is below the Tier 1 levels, no further action is required as to the group of chemicals unless otherwise specified in these rules. Group one consists of benzene, ethylbenzene, toluene, and xylenes (BTEX). Group two consists of naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene; TEH default values are incorporated into the Iowa Tier 1 Look-Up Table and Appendix A for group two chemicals.

d. Site classification. A site can be classified as no action required only after all pathways have met the conditions for pathway clearance as provided in this rule.

e. Groundwater sampling procedure. Groundwater sampling and field screening must be conducted in accordance with department Tier 1 guidance. A minimum of three properly constructed groundwater monitoring wells must be installed, subject to the limitations on maximum drilling depths, for the purpose of identifying maximum concentrations of groundwater contamination, suspected sources of releases, and groundwater flow direction.

(1) Field screening must be used to locate suspected releases and to determine locations with the greatest concentrations of contamination. Field screening is required as per department guidance at each former and current tank basin, each former and current pump island, along the piping, and at any other areas of actual or suspected releases. In placing monitoring wells, the following must be considered: field screening data, available current and historical information regarding the releases, tank and piping layout, site conditions, and drilling data available from sites in the vicinity. At least one well must be placed at each suspected source of release which shall include at a minimum: the pump island with the greatest field screening level, each current and former underground storage tank basin, and if field screening shows greater levels than at the pump islands or tank basins, at other suspected sources of releases. As a general rule, wells should be installed outside of the tank basin through native soils but as close to the tank basin as feasible. A well must be installed in a presumed downgradient direction and within 30 feet of the sample with the greatest field screening level. Three of the wells must be placed in a triangular arrangement to determine groundwater flow direction.

(2) Where the circumstances which prompt a Tier 1 assessment identify a discrete source and cause of a release, and the groundwater professional is able to rule out other suspected sources or contributing sources such as pump islands, piping runs and tank basins, the application of field screening and groundwater well placement may be limited to the known source.

f. Soil sampling procedure. The objective of soil sampling is to identify the maximum concentrations of soil contamination in the vadose and saturated zones and to identify sources of releases. The same principles stated above apply to soil sampling. Soil samples must be taken from borings with the greatest field screening levels even if the boring will not be converted to a monitoring well. At a minimum, soil and groundwater samples must be collected for analysis from all borings which are converted to monitoring wells.

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*. Standards in the Diesel column apply to all low volatile petroleum hydrocarbons except waste oil.

135.9(2) *Conditions requiring Tier 1 site assessment.* Unless owners and operators choose to conduct a Tier 2 assessment, the presence of bedrock requires a Tier 2 assessment as provided in 135.8(5), or these rules otherwise require preparation of a Tier 2 site assessment, a Tier 1 site assessment must be completed in response to release confirmation as provided in rule 135.6(455B), or tank closure investigation under 135.15(455B), or other reliable laboratory analysis which confirms the presence of contamination above the action levels in 135.14(455B).

135.9(3) *Tier 1 assessment report.* Unless directed to do otherwise by the department or the owners or operators choose to prepare a Tier 2 site cleanup report, owners and operators must assemble information about the site and the nature of the release in accordance with the department Tier 1 guidance, including information gained while confirming the release under 135.6(455B), tank closure under 135.15(455B) or completing the initial abatement measures in 135.7(1) and 135.7(2). This information must include, but is not necessarily limited to, the following:

a. Data on the nature and estimated quantity of release.

b. Results of any release investigation and confirmation actions required by subrule 135.6(3).

c. Results of the free product investigations required under 135.7(3)*"a"*(6), to be used by owners and operators to determine whether free product must be recovered under 135.7(5).

d. Chronology of property ownership and underground storage tank ownership, identification of the person(s) having control of, or having responsibility for the daily operation of the underground storage tanks and the operational history of the underground storage tank system. The operational history shall include, but is not limited to, a description of or suspected known subsurface or aboveground releases, past remediation or other corrective action, type of petroleum product stored, recent tank and piping tightness test results, any underground storage tank system repairs, upgrades or replacements and the underground storage tank and piping leak detection method being utilized. The operational history shall confirm that current release detection methods and record keeping comply with the requirements of 135.5(455B), that all release detection records have been reviewed and report any evidence that a release detection standard has been exceeded as provided in 135.5(4) and 135.5(5).

e. Appropriate diagrams of the site and the underground storage tank system and surrounding land use, identifying site boundaries and existing structures and uses such as residential properties, schools, hospitals, child care facilities and a general description of relevant land use restrictions and known future land use.

f. Current proof of financial responsibility as required by 136.19(455B) and 136.20(455B) and the status of coverage for corrective action under any applicable financial assurance mechanism or other financial assistance program.

g. A receptor survey including but not limited to the following: existing buildings, enclosed spaces (basements, crawl spaces, utility vaults, etc.), conduits (gravity drain lines, sanitary and storm sewer mains and service lines), plastic water lines and other utilities within 500 feet of the source. For conduits and enclosed spaces there must be a description of construction material, conduit backfill material, slope of conduit and trenches (include flow direction of sewers), burial depth of utilities or subsurface enclosed spaces, and the relationship to groundwater elevations.

h. An explosive vapor survey of enclosed spaces where there may be the potential for buildup of explosive vapors. The groundwater professional must provide a specific justification for not conducting an explosive vapor survey.

i. A survey of all surface water bodies within 200 feet of the source.

j. A survey of all active, abandoned and plugged groundwater wells within 1,000 feet of the source with a description of construction and present or future use.

k. Accurate and legible site maps showing the location of all groundwater monitoring wells, soil borings, field screening locations and screening values, and monitoring well and soil boring construction logs.

l. A tabulation of all laboratory analytical results for chemicals of concern and copies of the laboratory analytical reports.

m. Results of hydraulic conductivity testing and description of the procedures utilized.

n. A Tier 1 site assessment in accordance with the department's Tier 1 guidance. The Tier 1 report shall be submitted on forms and in a format prescribed by this guidance. The Tier 1 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

135.9(4) *Groundwater ingestion pathway assessment.* The groundwater ingestion pathway addresses the potential for human ingestion of petroleum-regulated substances from existing groundwater wells or potential drinking water wells.

a. Pathway completeness. This pathway is considered complete if: (1) there is a drinking or non-drinking water well within 1,000 feet of the source(s) exhibiting the maximum concentrations of the chemicals of concern; or (2) the first encountered groundwater is a protected groundwater source.

b. Receptor evaluation. A drinking or non-drinking water well within 1,000 feet of the source(s) is an actual receptor. The Tier 1 levels for actual receptors apply to drinking water wells and the Tier 1 levels for potential receptors apply to non-drinking water wells. Potential receptor points of exposure exist if the first encountered groundwater is a protected groundwater source but no actual receptors presently exist within 1,000 feet of the source.

c. Pathway clearance. If the pathway is incomplete, no further action is required for this pathway. If the Tier 1 level for actual or potential receptors is not exceeded, no further action is required for this pathway. Groundwater wells that are actual or potential receptors may be plugged in accordance with 567—Chapter 39 and 567—Chapter 49 and may result in no further action clearance if the groundwater is not a protected groundwater source and the pathway is thereby incomplete.

d. Corrective action response. If maximum concentrations exceed the applicable Tier 1 levels for either actual or potential receptors, a Tier 2 assessment must be conducted unless effective institutional controls are implemented as provided below. Technological controls are not acceptable at Tier 1 for this pathway. Abandonment and plugging of drinking and non-drinking water wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

e. Use of institutional controls. To apply an effective institutional control, if drinking or non-drinking water wells are present within 1,000 feet of the source, and the applicable Tier 1 level is

exceeded, the well(s) for which there is an exceedence must be properly plugged. If the groundwater is a protected groundwater source and the maximum concentrations do not exceed the Tier 1 level for potential receptors but do exceed the Tier 1 level for actual receptors, the owner or operator must provide notification of site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

If the groundwater is a protected source and the maximum concentrations exceed the Tier 1 level for potential receptors, the owner or operator must (1) implement an institutional control prohibiting the use of the groundwater for installation of drinking and non-drinking water wells within 1,000 feet of the source; and (2) provide notification as provided above. If an effective institutional control is not feasible, a Tier 2 assessment must be performed for this pathway in accordance with rule 135.10(455B).

f. Receptor evaluation for public water supply wells. Rescinded IAB 3/11/09, effective 4/15/09.

135.9(5) *Soil leaching to groundwater pathway assessment.* This pathway addresses the potential for soil contamination to leach to groundwater creating a risk of human exposure through the groundwater ingestion pathway.

a. Pathway completeness. If the groundwater ingestion pathway is complete, the soil leaching to groundwater pathway is considered complete.

b. Receptor evaluation. There is a single receptor type for this pathway and one applicable Tier 1 level.

c. Pathway clearance. If the pathway is incomplete or the pathway is complete and the maximum concentrations of chemicals of concern do not exceed the Tier 1 levels, no further action is required for assessment of this pathway.

d. Corrective action response. If the Tier 1 levels are exceeded for this pathway, a Tier 2 assessment must be conducted or alternatively, institutional controls or soil excavation may be undertaken in accordance with 135.9(7)*"h."*

e. Use of institutional controls. Institutional controls must satisfy the conditions applicable to the groundwater ingestion pathway as provided in 135.9(4)*"e."*

135.9(6) *Groundwater vapor to enclosed space pathway assessment.* This pathway addresses the potential for vapors from contaminated groundwater to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes the health-based Tier 1 levels will adequately protect against any associated short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway and the Tier 1 level applies regardless of the existence of actual or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum groundwater concentrations do not exceed the Tier 1 levels for this pathway.

e. Corrective action response. If the maximum concentrations exceed the Tier 1 levels for this pathway, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented. Technological controls are not acceptable at Tier 1 for this pathway.

f. Use of institutional controls. An institutional control must be effective to prohibit the placement of enclosed space receptors within 500 feet of the source.

135.9(7) *Soil vapor to enclosed space pathway assessment.* This pathway addresses the potential for vapors from contaminated soils to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes health-based screening levels at Tier 1 will adequately protect against short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway, and the Tier 1 level applies regardless of existing or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum soil concentrations do not exceed the Tier 1 levels for this pathway. If the Tier 1 levels are exceeded, soil gas measurements may be taken in accordance with the Tier 2 guidance at the area(s) of maximum concentration. Subject to confirmation sampling, if the soil gas measurements do not exceed the target levels in 135.10(7)*"f,"* no further action is required for this pathway. If the Tier 1 level is not exceeded but the soil gas measurement exceeds the target level, further action is required for the pathway.

e. Soil gas samples. To establish that the soil gas measurement is representative of the highest expected levels, a groundwater professional must obtain two soil gas samples taken at least two weeks apart. One of the samples must be taken below the typical frostline depth during a seasonal period of lowest groundwater elevation.

f. Corrective action response. If the maximum concentrations exceed the Tier 1 levels and the soil gas measurements exceed target levels for this pathway, or if no soil gas measurement was taken, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented or soil excavation is conducted as provided below. Technological controls are not acceptable at Tier 1 for this pathway.

g. Use of institutional controls. An institutional control must be effective to eliminate the placement of enclosed space receptors within 500 feet of the source.

h. Soil excavation. Excavation of contaminated soils for the purpose of removing soils contaminated above the Tier 1 levels is permissible as an alternative to conducting a Tier 2 assessment. Adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum, one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm that remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base.

135.9(8) *Groundwater to plastic water line pathway assessment.* This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and causing infusion to the drinking water.

a. Pathway completeness and receptor evaluation.

(1) Actual receptors. This pathway is considered complete for an actual receptor if there is an existing plastic water line within 200 feet of the source and the first encountered groundwater is less than 20 feet below ground surface.

(2) Potential receptors. This pathway is considered complete for a potential receptor if the first encountered groundwater is less than 20 feet below ground surface.

b. Pathway clearance. If the pathway is not complete, no further action is required for this pathway. If the pathway is complete and the maximum concentrations of all chemicals of concern do not exceed the Tier 1 levels for this pathway, no further action is required for this pathway.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response.

(1) For actual receptors, if the Tier 1 levels are exceeded, all plastic water lines within 200 feet must be replaced with nonplastic lines or the plastic lines must be relocated beyond the 200-foot distance. A Tier 2 assessment must be conducted for this pathway if lines are not replaced or relocated.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway.

135.9(9) *Soil to plastic water line pathway assessment.* This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and infusion into the drinking water.

a. Pathway completeness.

(1) Actual receptors. This pathway is considered complete for an actual receptor if a plastic water line exists within 200 feet of the source.

(2) Potential receptors. This pathway is always considered complete for potential receptors.

b. Pathway clearance. If the pathway is not complete for actual receptors, no further action is required for this pathway. If the pathway is complete for actual receptors and the maximum concentrations of all chemicals of concern do not exceed Tier 1 levels for this pathway, no further action is required. For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response. For actual receptors, if the Tier 1 levels are exceeded for this pathway, the plastic water lines may be replaced with nonplastic lines or the plastic lines must be relocated to a distance beyond 200 feet of the source. Excavation of soils to below Tier 1 levels may be undertaken in accordance with 135.9(7)*"h."* If none of these options is implemented, a Tier 2 assessment must be conducted for this pathway.

135.9(10) *Surface water pathway assessment.* This pathway addresses the potential for contaminated groundwater to impact surface water bodies creating risks to human health and aquatic life.

a. Pathway completeness. This pathway is considered complete if a surface water body is present within 200 feet of the source. For purposes of Tier 1, surface water bodies include both general use segments and designated use segments as provided in 567—subrule 61.3(1).

b. Receptor evaluation. The Tier 1 levels for this pathway only apply to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). The point of compliance is the source with the highest concentrations of chemicals of concern. General use segments of surface water bodies as provided in 567—paragraph 61.3(1)*"a"* are only subject to the visual inspection criteria.

c. Visual inspection requirements. A visual inspection of all surface water bodies within 200 feet of the source must be conducted to determine if there is evidence of a sheen on the water or there is evidence of petroleum residue along the bank. If a sheen or residue is evident or has been reported to be present, the groundwater professional must make a sufficient investigation to reasonably determine its source. If in the opinion of the groundwater professional, the sheen is not associated with the underground storage tank site, the professional must report and reasonably justify this opinion. If in the opinion of the groundwater professional the sheen is not a petroleum-regulated substance, a sample must be laboratory tested in accordance with 135.16(455B) to confirm it is not a petroleum-regulated substance.

d. Pathway clearance. If the pathway is not complete or it is complete and the maximum concentrations of all chemicals of concern at the point of compliance do not exceed the Tier 1 levels and there is no petroleum sheen or residue attributable to the site, no further action is required for assessment of this pathway.

e. Corrective action response. If a Tier 1 level is exceeded for any chemical of concern for a designated use segment within 200 feet of the source, or the groundwater professional determines the presence of a petroleum-regulated substance sheen or residue, a Tier 2 assessment of this pathway must be conducted.

135.9(11) *Tier 1 submission and review procedures.*

a. Within 90 calendar days of release confirmation or another reasonable period of time determined by the department, owners and operators must submit to the department a Tier 1 report in a format prescribed by the department and in accordance with these rules and the department Tier 1 guidance.

b. If the owner or operator elects to prepare a Tier 2 site cleanup report instead of a Tier 1 assessment, the department must be notified in writing prior to the expiration of the Tier 1 submission deadline. The Tier 2 site cleanup report must be submitted to the department in accordance with rule 135.10(455B) within 180 calendar days of release confirmation or another reasonable period of time determined by the department.

c. Tier 1 report completeness and accuracy. A Tier 1 report is considered to be complete if it contains all the information and data required by this rule and the department Tier 1 guidance. The report is accurate if the information and data is reasonably reliable based first on application of the standards in these rules and department guidance and second, generally accepted industry standards.

d. The certified groundwater professional shall include the following certification with the Tier 1 site assessment report:

I, _____, Groundwater Professional Certification No. _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, 567—Chapter 135 and the Department of Natural Resources Tier 1 guidance. Based on my knowledge of those documents and information I have prepared and reviewed regarding this site, UST Registration No. _____, LUST No._____ I certify that this document is complete and accurate as provided in 567 IAC 135.9(11)*"c"* and meets the applicable requirements of the Tier 1 site assessment.

Signature:

Date:

e. Upon receipt of the Tier 1 report, the department may review it by reliance on the groundwater professional's certification and a summary review for completeness and accuracy or may undertake a more complete review to determine completeness and accuracy and compliance with department rules and guidance. If the Tier 1 report proposes to classify the site "no action required," the department may review the report as provided in 135.9(11)*"g."*

f. If a "no action required" site classification is not proposed, the department must within 60 days approve the Tier 1 report for purposes of completeness or disapprove of the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this time period, the report is deemed to be accepted for purposes of completeness. The department retains the authority to review the report at the time a no action required site classification is proposed.

g. No action required site classification review. The department will review each Tier 1 report which proposes to classify a site as "no action required" to determine whether the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.9(12) *Tier 1 site classification and corrective action response.*

a. No action required site classification. At Tier 1, a site is only eligible for a "no action required" classification. To be classified as no action required, each pathway must meet the requirements for pathway clearance as specified in this rule. If the department determines a no action required site classification is appropriate, a no further action certificate will be issued as provided in 135.12(10).

b. Where an individual pathway or a chemical group meets the requirements for clearance but the site is not entitled to a no action required classification, only those pathways and chemical groups which do not meet the no further action requirements must be evaluated as part of a Tier 2 assessment as provided in rule 135.10(455B).

c. Compliance monitoring and confirmation sampling. Compliance monitoring is not an acceptable corrective action at Tier 1. Except for soil gas sampling under 135.9(7), confirmation sampling to verify a sample does not exceed a Tier 1 level is not required. However, the department retains the authority to require confirmation sampling from existing groundwater monitoring wells if a no action required classification is being proposed at Tier 1 and the department has a reasonable basis

to question the representative validity of the samples based on, for example, the seasonal bias of the sampling, evidence of multiple sources of releases, marginal groundwater monitoring well locations and analytical variability.

d. Expedited corrective action. Expedited corrective action is permissible in accordance with 135.12(11).

[**ARC 7621B**, IAB 3/11/09, effective 4/15/09]

567—135.10(455B) Tier 2 site assessment policy and procedure.

135.10(1) *General conditions.* A Tier 2 site assessment must be conducted and a site cleanup report submitted for all sites which have not obtained a no action required site classification and for all pathways and chemicals of concern groups that have not obtained no further action clearance as provided in 135.9(455B). If in the course of conducting a Tier 2 assessment, data indicates the conditions for pathway clearance under Tier 1 no longer exist, the pathway shall be further assessed under this rule. The Tier 2 assessment and report must be completed whenever free product is discovered as provided in 135.7(455B). If the owner or operator elects to complete the Tier 2 site assessment without doing a Tier 1 assessment, all the Tier 1 requirements as provided in 135.9(455B) must be met in addition to requirements under this rule.

a. Guidance. The Tier 2 site assessment shall be conducted in accordance with the department's "Tier 2 Site Assessment Guidance" and these rules. The site cleanup report shall be submitted on forms and in a format prescribed by this guidance. The Tier 2 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

b. Classification. At Tier 2, individual pathways may be classified as high risk or low risk or no action required and separate classification criteria may apply to actual and potential receptors for any pathway. A single pathway may have multiple classifications based on actual or potential receptor evaluations. A pathway must meet both the criteria for actual and potential receptors for the pathway to obtain a classification of no action required. Sites may have multiple pathway classifications. For a site to obtain a no action required classification, all pathways must meet the individual pathway criteria for no action required classification.

c. Public right-of-way. As a general rule, public right-of-way will not be considered an area of potential receptor exposure except for potential sanitary sewer evaluation under the soil and groundwater vapor pathways, subrules 135.10(6) and 135.10(7).

135.10(2) *General Tier 2 assessment procedures.*

a. Objectives. The objective of a Tier 2 assessment is to collect site-specific data and with the use of Tier 2 modeling determine what actual or potential receptors could be impacted by chemicals of concern and what concentrations at the source are predicted to achieve protection of these receptors. Both Tier 1 and Tier 2 are based on achieving similar levels of protection of human health, safety and the environment.

b. Groundwater modeling. Tier 2 uses fate and transport models to predict the maximum distance groundwater contamination is expected to move and the distribution of concentrations of chemicals of concern within this area. The model is used for two basic purposes. One, it is used to predict at what levels of concentration contamination would be expected to impact actual and potential receptors. Two, it is used to determine a concentration at the source which if achieved, and after dispersion and degradation, would protect actual and potential receptors at the point of exposure. In predicting the transport of contaminants, the models assume the contaminant plume is at "steady state" such that concentrations throughout the plume have reached a maximum level and are steady or decreasing. The Tier 2 models are only designed to predict transport in a direct line between the source and downgradient to a receptor. In order to more reasonably define a modeled plume in all directions, paragraph *"i"* defines a method of decreasing modeled concentrations as a percentage of their distance in degrees from the downgradient direction.

c. Soil vapor models. The soil vapor models are vertical transport models and do not use modeling to predict soil contaminant transport horizontally to receptors.

d. Soil leaching to groundwater modeling. The soil leaching to groundwater model is a model that predicts the maximum concentrations of chemicals of concern that would be expected in groundwater due to vertical leaching from the area of maximum soil concentrations and then incorporates the groundwater transport models to predict contaminant transport through groundwater pathways.

e. Modeling default parameters. The Tier 2 model formulas and applicable parameters are designated in Appendix B and must be followed unless otherwise specified in these rules. Unless otherwise specified, target levels at a point of exposure may be the Tier 1 level(s) or may be determined using site-specific parameters. The target level at a point of exposure is calculated using the Tier 1 formulas in Appendix A and either site-specific measurements or the default values for those parameters identified as "optional" and "site-specific" in Appendix B.

f. Source width. The source width and source length are variables used in modeling and must be determined by the following criteria and as specified in the department's Tier 2 guidance. The following are not to be used as criteria for defining the extent of the contaminant plumes.

(1) Source width (equals S_w in models) for groundwater transport modeling. The sum of group one chemical (benzene, toluene, ethylbenzene, xylenes or "BTEX") concentrations for each groundwater sample is determined and the location of the sample with the maximum total BTEX is identified. Linear interpolation is used to estimate the area where groundwater concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width measurement. The same procedure is used to determine source width for group two chemicals, using TEH in groundwater. The width of the groundwater contamination perpendicular to estimated groundwater flow direction (S_w) is determined, and the larger of either group one or group two chemicals is used in the groundwater transport model.

(2) Source width (S_w) and source length (equals W in models) for soil leaching to groundwater transport modeling. Both the source width perpendicular to the estimated groundwater flow direction (S_w) and the source length parallel to the estimated groundwater flow direction (W) are used in the soil leaching to groundwater model. The sum of BTEX concentrations for each soil sample is determined and the location of the sample with the maximum total BTEX is identified. Concentrations from both the vadose zone and the saturated zone must be considered when determining the maximum. Linear interpolation is used to estimate the area where soil concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width and source length measurements. The same procedure is used to determine source width for group 2 chemicals, using TEH in soil. Source width and source length measurements for BTEX in groundwater are also taken following the same linear interpolation criteria in *"f"*(1) above. The source width value used in the model is the greatest of either the soil source width measurements or the groundwater source width measurement. The source length value used in the model is the greatest of either of the soil source length measurements or the groundwater length measurement.

(3) Estimating source width when free product is present. Groundwater from wells with free product must be analyzed for BTEX and the source width and source length are estimated using the criteria in 135.10(2)*"f"*(1) and 135.10(2)*"f"*(2) above. For those sites with approved site cleanup reports and free product present in wells but actual BTEX values are not available, source width and source length may be estimated in accordance with 135.10(2)*"f"*(1) and 135.10(2)*"f"*(2) using the default BTEX values for groundwater in 135.18(4) or estimated by using the area representing half the distance between wells with free product and wells without free product, whichever method is greater.

g. Modeled simulation line. The simulation line represents the predicted maximum extent of groundwater contamination and distribution of contaminant concentrations between the source(s) and actual or potential receptor locations. The model calculates the simulation line using maximum concentrations at the source(s) and predicting the amount of dispersion and degradation. Modeled data in the simulation line are compared with actual field data to verify the predictive validity of the model and to make risk classification decisions.

h. Modeled site-specific target level (SSTL) line. The modeled SSTL line represents acceptable levels of contaminant concentrations at points between and including the source(s) and an applicable point(s) of exposure or other point(s) of compliance (ex. a potential receptor point of exposure). The

SSTL line is calculated by assuming an applicable target level concentration at the point(s) of exposure or point(s) of compliance and modeling back to the source to determine the maximum concentrations at the source (SSTL) that must be achieved to meet the target level at the point of exposure or compliance. Comparison of field data to this SSTL line is used to determine a risk classification and determine appropriate corrective action response.

i. Crossgradient and upgradient modeling. In determining the SSTL line and the simulation line in directions other than downgradient, the modeled contaminant concentrations are applied to reduced distances, as specified in the "Tier 2 Guidance." The modeled results are applied to 100 percent of the distance within an angle of 30 degrees on either side of the range of downgradient directions, as specified in Tier 2 guidance. The modeled results are applied to 20 percent of the distance in the upgradient direction and directly proportional distances between these two outer limits. If the groundwater gradient is less than 0.005 or the groundwater contaminant plume shows no definitive direction or shows directional reversals, the modeled concentrations are applied to 100 percent of the distance in all directions from the source. As the downgradient velocity increases, the upgradient modeled distance is reduced to less than 20 percent of the downgradient modeled distance.

j. Plume definition. The purpose of plume definition at Tier 2 is to obtain sufficient data to determine the impact on actual and potential receptors, to determine and confirm the highest levels of contamination, to verify the validity of the models, and to determine groundwater flow direction. The number and location of borings and monitoring wells and the specificity of plume definition will depend on the pathway or pathways being assessed and the actual or potential receptors of concern. Unless otherwise specified, groundwater and soil contamination shall be defined to Tier 1 levels for the applicable pathways. Linear interpolation between two known concentrations must be used to delineate plume extent. Samples with no concentrations detected shall be considered one-half the detection limit for interpolation purposes.

k. Pathway completeness. Unless a pathway has obtained clearance under Tier 1, each pathway must be evaluated at Tier 2. Pathways are generally considered complete (unless otherwise specified) and receptors affected if actual receptors or potential receptor points of exposure exist within the modeled contaminant plume using the modeled simulation line calculated to the applicable target level at a point of exposure. If the actual contaminant plume exceeds the modeled plume, the pathway is complete and must be evaluated if actual or potential points of exposure exist within a distance extending 10 percent beyond the edge of the defined plume.

l. Points of exposure and compliance. For actual receptors, the point(s) of exposure is the receptor. For potential receptors, the potential receptor point(s) of exposure is determined by using actual plume definition or the modeled simulation line to determine all points which exceed the target level(s) for potential receptors. The potential receptor point(s) of exposure is the location(s) closest to the source where a receptor could reasonably exist and which is not subject to an institutional control; for example, the source is the potential receptor point of exposure if not subject to an institutional control or an adjoining property boundary line if that property is not subject to an institutional control. At Tier 2, the point(s) of exposure or potential receptor point(s) of exposure is a point of compliance unless otherwise specified. Other points of compliance are specified by rules and will generally include all points along the SSTL line for purposes of pathway and site classification and corrective action response.

m. Group two chemicals. At Tier 2, chemical-specific values for the four chemicals may be used or the largest of the four TEH default values. (Refer to Appendix B and department Tier 2 guidance for using the TEH conversion method for modeling.) If chemical-specific values are used, the analytical method must be approved by the department prior to its use.

135.10(3) Bedrock assessment.

a. General. As provided in 135.8(5), if bedrock is encountered before groundwater, special assessment procedures under this subrule apply. The Tier 2 assessment procedures apply to the extent they are not inconsistent with this subrule. The objectives of these special procedures are to avoid creating a preferential pathway for contamination through a confining layer to a bedrock aquifer; to avoid creating a preferential pathway to a fractured system, and to determine whether groundwater transport modeling can be used and, if not, what alternative procedures are required. The owner or

operator may choose to conduct a Tier 3 assessment under 135.11(455B) as an alternative to proceeding under this subrule. For sites where bedrock is encountered before groundwater, there are three general categories of site conditions which determine the assessment procedures that apply:

(1) Nongranular bedrock. Nongranular bedrock is bedrock which is determined to not act as a granular aquifer as provided in subparagraph (2). Nongranular bedrock generally has some type of fractured system where groundwater transport modeling cannot be applied and which makes it difficult to define the extent of contamination.

(2) Granular bedrock. Granular bedrock is bedrock which is determined to act as a granular aquifer and for which monitoring wells do not exist at the source as of August 15, 1996. For purposes of this rule, a granular aquifer is one that shows no extraordinary variations or inconsistencies in groundwater elevations across the site, groundwater flow, hydraulic conductivities, or total dissolved solid concentrations among monitoring wells. Although the extent of contamination can be defined in granular bedrock, groundwater transport modeling cannot be used because there are no monitoring wells at the source.

(3) Exempt granular bedrock. Exempt granular bedrock is bedrock which is determined to act as a granular aquifer as provided in subparagraph (2) and for which monitoring wells exist at the source as of August 15, 1996. Sites in exempt granular bedrock shall be evaluated using the normal Tier 1 or Tier 2 procedures in this rule. Nongranular bedrock is not exempt from this subrule even if groundwater monitoring wells exist at the source.

b. Exempt soil pathways. The soil vapor to enclosed space pathway and the soil to plastic water lines pathway shall be assessed under the normal Tier 2 procedures in subrules 135.10(7) and 135.10(9) respectively. In all cases, the normal assessment must comply with the policy of avoiding a preferential pathway to groundwater consistent with 135.8(5) and this subrule.

c. Soil and groundwater assessment. The vertical and horizontal extent of soil contamination shall first be defined to Tier 1 levels for the soil leaching to groundwater pathway without drilling into bedrock. A minimum of three groundwater monitoring wells shall be located and installed between 50 to 100 feet beyond the soil contamination Tier 1 levels to avoid creating a preferential pathway. Analytical data as normally required by these rules and guidance must be obtained.

d. Soil contamination remediation. For all sites where soil contamination exceeds the soil leaching to groundwater Tier 1 levels, soil excavation or other active soil remediation technology must be conducted in accordance with department guidance to reduce concentrations to below this Tier 1 level. Soil remediation monitoring must be conducted in accordance with 135.12(455B).

e. Groundwater plume definition. If it is determined the groundwater acts in a manner consistent with a granular aquifer as provided in subparagraph *"a"*(2) and guidance but does not meet the criteria for exemption under subparagraph *"a"*(3), the plume must be defined. The policy of avoiding the creation of a preferential pathway to the bedrock aquifer in accordance with 135.8(5) must be followed.

f. Soil leaching to groundwater ingestion pathway. Under this subrule, the soil leaching to groundwater pathway only need be evaluated in combination with the groundwater ingestion pathway. Because of the policies requiring soil remediation to the soil leaching to groundwater Tier 1 levels under paragraphs *"d"* and *"k,"* the soil leaching pathway target levels applicable to other groundwater transport pathways and other soil pathways would not be exceeded. If a soil leaching to groundwater Tier 1 level is exceeded, the pathway is high risk.

g. Special procedures for the groundwater ingestion pathway.

(1) A protected groundwater source is assumed without measurements of hydraulic conductivity for all sites designated as granular or nongranular bedrock.

(2) Groundwater well receptor evaluation for granular and nongranular bedrock designations. All drinking and non-drinking water wells within 1,000 feet of the source must be identified and tested for chemicals of concern. All public water supply systems within one mile of the source must be identified and raw water tested for chemicals of concern. If no drinking water wells are located within 1,000 feet of the source, all the area within 1,000 feet is considered a potential receptor point of exposure.

(3) Target levels. The following target levels apply regardless of granular aquifer designation. If drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater

ingestion pathway Tier 1 level for actual receptors. If non-drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors. For potential wells, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors.

(4) Sentry well. If the Tier 1 level for actual receptors is exceeded at sites designated as granular bedrock and the receptor has not yet been impacted, a monitoring well shall be placed between the source and an actual receptor, outside the defined plume and approximately 200 feet from the actual receptor. For alternative well placement, the certified groundwater professional must provide justification and obtain department approval. This monitoring well is to be used for monitoring potential groundwater contamination of the receptor.

(5) High risk classification. A site where bedrock is encountered before groundwater shall be classified high risk for this pathway if any of the following conditions exist regardless of granular aquifer determination: The target level at any actual receptor is exceeded; drinking water well receptors are present within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors; non-drinking water wells are within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion pathway Tier 1 level for potential receptors; or for sites designated nongranular bedrock, if groundwater concentrations for chemicals of concern from any public water system well within one mile of the source exceed 40 percent of the Tier 1 level for actual receptors, and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors. Corrective action shall be undertaken as provided in paragraph *"k."*

(6) Low risk classification. Sites without an actual receptor within 1,000 feet shall be classified as low risk for this pathway if no high risk conditions exist, and the Tier 1 level for potential receptors is exceeded. The site is subject to monitoring as provided in paragraph *"l."* If an actual receptor exists within 1,000 feet, a site designated as granular or nongranular bedrock shall be classified low risk for this pathway when soil contamination has been removed or remediated to below the soil leaching to groundwater Tier 1 levels, and all groundwater monitoring wells are non-detect or below the applicable target level for actual and potential receptors. A site may be reclassified to no action required for this pathway after all monitoring wells meet the exit monitoring criteria as specified in paragraph *"l."* (NOTE: Exit monitoring is required because groundwater monitoring wells are not located at the source or if they are, the data is highly unreliable given the nature of bedrock.) If actual receptors do not exist or have been properly plugged and concentrations exceed the Tier 1 level for potential receptors, institutional controls and notification to permitting authorities may be employed in accordance with 135.10(4)*"i."* The institutional control must prohibit use of groundwater for 1,000 feet.

h. Special procedures for the groundwater vapor to enclosed space pathway.

(1) Soil gas plume. Soil gas measurements must be taken regardless of granular aquifer determination and in accordance with Tier 2 guidance to determine a soil gas plume. Soil gas where practical should be measured at the soil-bedrock interface. At a minimum, soil gas must be measured at the suspected area of maximum contamination and near the three monitoring wells with the highest concentrations that exceed the Tier 1 level for the groundwater to enclosed space pathway. Where the plume has been defined, soil gas measurements should be taken near wells exceeding the Tier 1 level. Other soil gas measurements must be taken as needed to define the extent of contamination where soil gas measurements exceed the soil gas vapor target levels.

(2) The soil gas target levels are those defined in 135.10(7)*"f."*

(3) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if an actual confined space receptor exists within 50 feet of the soil gas plume based on the soil gas target level as defined in 135.10(6).

(4) Low risk classification. A site designated as granular or nongranular bedrock shall be classified as low risk for this pathway if the soil gas exceeds the vapor target level at any point and no actual confined space receptors exist within 50 feet of the soil gas contaminant plume.

i. Special procedure for the groundwater to plastic water line pathway.

(1) Target level. The applicable target level is the Tier 1 level for plastic water lines.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the highest groundwater elevation is higher than three feet below the bottom of a plastic water line as provided in 135.10(8)*"a"*(1), risk classification cannot be determined as provided in 135.12(455B) due to limitations on placement of monitoring wells, and plastic water lines exist within 200 feet of a monitoring well which exceeds the Tier 1 level.

j. Special procedures for the surface water pathway. Any surface water body within 200 feet of the source must be evaluated under the following for sites designated as granular or nongranular bedrock. The provisions of 135.10(10) apply to the extent they are not inconsistent with the following, including the visual inspection requirements.

(1) Point of compliance. The monitoring well closest to the surface water body must be used as the point of compliance to evaluate impacts to designated use segments as described in 135.10(10) and for general use segments that fail the visual inspection criteria of 135.10(10)*"b."* If the surface water criteria is exceeded for a designated use segment, an allowable discharge concentration must be calculated and met at the point of compliance. For general use segments failing the visual inspection criteria, the acutely toxic target level must be met at the point of compliance.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the surface water body is within 200 feet of the source, risk classification cannot be determined as per 135.12(455B) due to limitations on placement of monitoring wells, and the monitoring well closest to the designated use segment exceeds the allowable discharge concentration. A general use segment failing the visual inspection criteria is high risk if, after the sheen is removed, the monitoring well closest to the general use segment exceeds the acutely toxic target level.

(3) Low risk classification. If the allowable discharge concentration is not exceeded at the point of compliance, the site shall be classified as low risk for this pathway and subject to monitoring under paragraph *"l."* The monitoring well closest to the receptor shall serve as the sentry well for monitoring purposes.

k. High risk corrective action response. Owners and operators have the option to conduct a Tier 3 assessment in accordance with 135.11(455B).

(1) Groundwater ingestion pathway. For high risk sites, where soil exceeds the soil leaching to groundwater Tier 1 level for actual receptors, soil excavation or other active remediation of soils must be conducted in accordance with department guidance to reduce soil concentrations below the soil leaching Tier 1 level. Corrective action other than monitoring of groundwater is required at sites designated as nongranular bedrock if the actual receptor has been or is likely to be impacted. Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if the actual receptor has been impacted or the sentry well required by 135.10(3)*"g"*(4) has been impacted above Tier 1 levels. Acceptable corrective action for impacted or vulnerable groundwater wells may include active remediation, technological controls, institutional controls, well plugging, relocation, and well reinstallation with construction measures sufficient to prevent contaminant infiltration to the well and to prevent formation of a preferential pathway.

(2) Groundwater ingestion pathway high risk monitoring. For high risk sites designated as nongranular or granular bedrock, if the soil concentrations do not exceed the soil leaching to groundwater Tier 1 levels or have been reduced to this level by corrective action, and corrective action of groundwater is not required as in subparagraph (1), these sites shall be subject to groundwater monitoring as provided in paragraph *"l."* Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if groundwater concentrations exceed the applicable target level less than 200 feet from an actual receptor. Reevaluation of the potential for impact to actual receptors is required at sites designated as nongranular bedrock if concentrations from monitoring wells increases more than 20 percent of the previous samples.

(3) Other pathways. For high risk sites other than groundwater ingestion, active remediation must be conducted to reduce concentrations below the applicable target levels including the use of institutional and technological controls.

l. Monitoring. For high and low risk sites, annual monitoring at a minimum is required as specified below, and potential receptor status for low risk sites must be confirmed. Annual monitoring

may be used to meet the exit requirements for no action required classification in accordance with paragraph *"m."*

(1) Groundwater in nongranular bedrock designations. All groundwater monitoring wells must be monitored at least annually.

(2) Groundwater in granular bedrock designations. The following monitoring wells must be monitored at least annually: a well with detected levels of contamination closest to the leading edge of the groundwater plume between the source and the receptor, and a sentry well with concentrations below the applicable target level consistent with subparagraph *"g"*(4) and paragraph *"j."*

(3) Soil gas. For sites where the soil gas target level is exceeded, annual monitoring of soil gas is required at the suspected area of maximum contamination and between the soil gas plume and any actual receptors within 100 feet of the soil gas plume.

m. No action required classification. A site may be given a no action required classification after conducting a Tier 2 assessment as provided in this subrule if maximum soil concentrations do not exceed the Tier 1 levels for the soil leaching pathway, and if groundwater exit monitoring criteria and soil gas confirmation sampling are met as specified below.

(1) Groundwater in nongranular bedrock designations. Exit monitoring requires that samples from all groundwater monitoring wells must not exceed the applicable target levels for annual sampling for three consecutive years.

(2) Groundwater in granular bedrock designations. Exit monitoring must be met in two ways: A monitoring well between the source and the receptor must not exceed applicable target levels for three sampling events, and samples must be separated by at least six months; and the three most recent consecutive groundwater samples from a monitoring well between the source and the receptor with detected levels of contamination must show a steady or declining trend and meet the following criteria: The first of the three samples must be more than detection limits, concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

(3) Soil gas. Confirmation sampling for soil gas must be conducted as specified in 135.12(6)*"c."*

n. After receiving a no action required classification, all monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49.

135.10(4) *Groundwater ingestion pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is complete and must be evaluated under any of the following conditions: (1) the first encountered groundwater is a protected groundwater source; or (2) there is a drinking water well or a non-drinking water well within the modeled groundwater plume or the actual plume as provided in 135.10(2)*"j"* and 135.10(2)*"k."*

b. Receptor evaluation. All drinking and non-drinking water wells located within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested, at a minimum, for chemicals of concern as part of the receptor evaluation. Actual plumes refer to groundwater plumes for all chemicals of concern. Untreated or raw water must be collected for analysis unless it is determined to be infeasible or impracticable.

All existing drinking water wells and non-drinking water wells within the modeled plume or the actual plume as provided in paragraph *"a"* must be evaluated as actual receptors. Potential receptors only exist if the groundwater is a protected groundwater source. Potential receptor points of exposure are those points within the modeled plume or actual plume that exceed the potential point of exposure target level. The point(s) of compliance for actual receptor(s) is the receptor. The point(s) of compliance for potential receptor(s) is the potential receptor point of exposure as provided in 135.10(2)*"j"* and 135.10(2)*"k."*

c. Target levels. For drinking water wells, the target level at the point(s) of exposure is the Tier 1 level for actual receptors. For non-drinking water wells, the target level at the point(s) of exposure is the Tier 1levels for potential receptors. For potential receptors, the target level at the potential receptor point(s) of exposure is the Tier 1 level for potential receptors.

d. The soil leaching to groundwater pathway must be evaluated in accordance with 135.9(5) if this pathway is complete.

e. Modeling. At Tier 2, the groundwater well located within the modeled plume is assumed to be drawing from the contaminated aquifer, and the groundwater transport model is designed to predict horizontal movement to the well. If the groundwater professional determines that assessment of the vertical movement of contamination is advisable to determine the potential or actual impact to the well source, a Tier 3 assessment of this vertical pathway may be conducted. The groundwater professional shall submit a work plan to the department specifying the assessment methods and objectives for approval in accordance with 135.11(455B). Factors which should be addressed include, but are not limited to, well depth and construction, radius of influence, hydrogeologic separation of aquifer, preferential pathways, and differing water quality characteristics.

f. Public water supply well assessment. Rescinded IAB 3/11/09, effective 4/15/09.

g. Plume definition. The groundwater plume shall be defined to the applicable Tier 1 level for actual receptors except, where there are no actual receptors and the groundwater is a protected groundwater source, the plume shall be defined to the Tier 1 level for potential receptors.

h. Pathway classification. This pathway shall be classified as high risk, low risk or no action required in accordance with 135.12(455B).

i. Corrective action response. Corrective action must be conducted in accordance with 135.12(455B). Abandonment and plugging of wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

j. Use of institutional controls. The use of institutional controls may be used to obtain no action required pathway classification. If the pathway is complete and the concentrations exceed the applicable Tier 1 level(s) for actual receptors, the drinking or non-drinking water well must be properly plugged in accordance with 567—Chapters 39 and 49 and the institutional control must prohibit the use of a protected groundwater source (if one exists) within the actual or modeled plume as provided in 135.10(2)*"j"* and 135.10(2)*"k."* If the Tier 1 level is exceeded for potential receptors, the institutional control must prohibit the use of a protected groundwater source within the actual or modeled plume, whichever is greater. If concentrations exceed the Tier 1 level for drinking water wells and the groundwater is a protected groundwater source, the owner or operator must provide notification of the site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

k. Notification of well owners. Upon receipt of a Tier 2 site cleanup report and as soon as practicable, the department shall notify the owner of any public water supply well identified within the Tier 2 site cleanup report that a leaking underground storage tank site is within 2,500 feet and an assessment has been performed.

135.10(5) *Soil leaching to groundwater pathway assessment.*

a. General. The soil leaching to groundwater pathway is evaluated using a one-dimensional model which predicts vertical movement of contamination through soil to groundwater and transported by the groundwater to a receptor. The model is used to predict the maximum concentrations of chemicals of concern that would be present in groundwater beneath a source which is representative of residual soil contamination and maximum soil concentrations. The predicted groundwater concentrations then must be used as a groundwater source concentration to evaluate its impact on other groundwater transport pathways, including the groundwater ingestion pathway, the groundwater vapor pathway, the groundwater plastic line pathway and the surface water pathway.

b. Pathway completeness. This pathway is complete whenever a groundwater transport pathway is complete as provided in this rule.

c. Plume definition. The soil plume shall be defined to the Tier 1 levels for the soil leaching to groundwater pathway.

d. Receptor evaluation. Receptors for this pathway are the same as the receptors for each complete groundwater transport pathway.

e. Modeling and target levels. The soil and groundwater parameters shall be measured as provided in 135.10(2).

The soil leaching to groundwater model shall be used to calculate the predicted groundwater source concentration. Each applicable groundwater transport pathway model shall then be used in accordance with the rules for that pathway to predict potential impact to actual receptors, the location of potential receptor points of exposure and the site-specific target level (SSTL) in groundwater at the source. This SSTL then is used to calculate a SSTL for soil at the source. If the soil concentrations exceed the SSTL for soil, corrective action response shall be evaluated.

f. Corrective action response. If the maximum soil concentration at the source exceeds the SSTL for soil for actual or potential receptors, corrective action must be taken in accordance with 135.12(455B).

135.10(6) *Groundwater vapor to enclosed space pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6)*"b"* and procedures outlined in the department's Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within the modeled groundwater plume or the actual groundwater plume as provided in 135.10(2)*"j"* and 135.10(2)*"k"* is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered confined spaces. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through actual or modeled groundwater contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs *"f"* and *"g."*

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas within the actual groundwater plume perimeter or modeled groundwater plume perimeter are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning as provided in paragraph *"f."* The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition.

(1) The soil plume must be defined in accordance with 135.10(2)*"f"* for the purposes of estimating source width and source length used in soil leaching to groundwater and groundwater transport models.

(2) The groundwater plume must be defined to the target levels derived from site-specific data as provided in paragraph *"f."*

f. Target levels. Target levels can be based on groundwater concentrations, soil gas measurements, and indoor vapor measurements as provided below.

(1) For actual receptors and potential receptors, groundwater modeling as provided in 135.10(2) is used to calculate the groundwater concentration target level at the point of exposure. Default residential exposure factors, default residential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in residential areas and areas with no zoning. Default nonresidential exposure factors, default nonresidential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in nonresidential areas. Default values are provided in Appendices A and B.

(2) For actual receptors, the indoor vapor target levels are designated in 135.10(7)*"f."* For actual and potential receptors, the soil gas target levels are designated in 135.10(7)*"f."*

(3) Sanitary sewers are treated as human health receptors, and groundwater concentration target levels at the point of exposure are based on the application of a target risk of 2×10^{-4} for carcinogens and a hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) Actual receptors. If it can be demonstrated that the groundwater plume has reached steady state concentrations under a confined space, indoor vapor measurements at the point(s) of exposure and soil gas measurements at an alternative point(s) of compliance may be used for the pathway evaluation. When assessing sanitary sewers for pathway clearance, soil gas measurements may be evaluated against the soil gas target levels; however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken and analyzed in accordance with 135.16(5) and the department's Tier 2 guidance, and at locations in the plume where measured groundwater concentrations exceed the levels which are projected by modeling to exist beneath the actual receptor. If measured groundwater concentrations beneath the actual receptor exceed the levels projected from modeling, then the soil gas measurements may be taken either adjacent to the actual receptor in areas expected to exhibit the greatest soil gas measurements or at an alternative point of compliance between the source and receptor where the actual groundwater concentrations exceed the groundwater concentrations which exist beneath the confined space. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6)*"c"* do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual confined space receptors shall be classified no action required. If the Tier 1 indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor groundwater concentration target level(s) is exceeded at any potential receptor point of exposure based on actual data or modeling, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in 135.10(7)*"f,"* the pathway, as to potential receptors, shall be classified no action required. If the target level(s) for potential sanitary sewer receptors is exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B). Actual receptors are subject to corrective actions which: (1) reduce groundwater concentrations beneath the enclosed space to below the target level; (2) reduce the measured soil gas levels to below the soil gas target levels; (3) reduce the indoor vapor concentrations to below the indoor vapor target level; or (4) reduce the vapor level to below 10 percent of the lower explosive limit (LEL), if applicable. Potential receptors are subject to the monitoring requirements in 135.12(5). Soil vapor monitoring may be conducted in lieu of groundwater monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where groundwater concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(7) *Soil vapor to enclosed space pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6)*"b"* and procedures outlined in the department's Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within 50 feet of the edge of the plume is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered receptors. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through soil contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs *"f"* and *"g."*

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas where soil concentrations are greater than the Tier 1 level applicable to residential areas or alternative target levels for nonresidential areas as specified in paragraph *"f"* are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning. An area with no zoning is considered residential. The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition. The soil plume must be defined to the Tier 1 level for this pathway unless vapor measurements taken at the area(s) with the maximum levels of soil contamination do not exceed the soil gas target level in 135.10(7)*"f."* If soil gas measurements taken from the area(s) of maximum soil concentration do not exceed target levels, confirmation sampling must be conducted in accordance with 135.12(6)*"c"* prior to proposing a no action pathway classification.

f. Target levels. Target levels can be based on soil concentrations, soil gas measurements, and indoor vapor measurements as provided below:

(1) For actual receptors, the soil concentration target level is the Tier 1 level. For potential receptors, the soil concentration target level for residential areas and areas with no zoning is the Tier 1 level. For areas zoned nonresidential, the target level is calculated using the default nonresidential exposure factors and building parameters from Appendix A and a target risk of 10^{-4}.

(2) The following indoor vapor target levels apply to actual receptors other than sanitary sewers and the soil gas target levels apply to all actual and potential receptors. These levels were derived from the ASTM indoor air inhalation and the soil vapor to enclosed space models designated in Appendix A.

	Indoor Vapor ($\mu g/m^3_{air}$)	**Soil Gas ($\mu g/m^3$)**
Benzene	39.2	600,000
Toluene	555	9,250,000

(3) Sanitary sewers are treated as human health receptors, and soil concentration target levels at the point of exposure are based on application of a target risk of 2×10^{-4} for carcinogens and hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification.

(1) Actual receptors. Confined space receptors may be evaluated using soil gas measurements and indoor vapor measurements. When assessing sanitary sewers for pathway clearance, soil gas

measurements may be evaluated against the soil gas target levels, however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken adjacent to the actual receptor or at an alternative point of compliance between the source and receptor such as the property boundary, and in accordance with 135.16(5) and the department's Tier 2 guidance. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6)*"c"* do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual receptors shall be classified no action required. If the indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor target level(s) based on soil concentrations is exceeded at any potential receptor point of exposure, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in paragraph *"f,"* the pathway shall be classified no action required as to potential receptors. If the target level(s) for potential sanitary sewer receptors is exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B) and in accordance with department Tier 2 guidance. Actual receptors are subject to corrective actions which: (1) reduce the indoor vapor concentrations to below the target level; (2) reduce measured soil gas levels to below the soil gas target levels; and (3) if applicable, reduce the vapor level to below 10 percent of the lower explosive limit (LEL). Potential receptors are subject to monitoring requirements as provided in 135.12(5). Soil vapor monitoring may be conducted in lieu of soil monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where soil concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(8) *Groundwater to plastic water line pathway assessment.*

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines where the highest groundwater elevation is higher than three feet below the bottom of the plastic line at the measured or predicted points of exposure. The highest groundwater elevation is the estimated average of the highest measured groundwater elevations for each year. All plastic water lines must be evaluated for this pathway regardless of distance from the source and regardless of the Tier 1 evaluation, if the lines are in areas with modeled data above the SSTL line. If actual data exceeds modeled data, then all plastic water lines are considered actual receptors if they are within a distance extending 10 percent beyond the edge of the contaminant plume defined by the actual data.

(2) Potential receptors include all areas where the first encountered groundwater is less than 20 feet deep and where actual data or modeled data are above Tier 1 levels.

(3) The point(s) of exposure is the plastic water line, and the points of compliance are monitoring wells between the source and the plastic water line which would be effective in monitoring whether the line has been or may be impacted by chemicals of concern.

b. Plume definition. If this pathway is complete for an actual receptor, the groundwater plume must be defined to the Tier 1 levels, with an emphasis between the source and any actual plastic water lines. The water inside the plastic water lines shall be analyzed for all chemicals of concern.

c. Target levels. Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern and site-specific target levels. The soil leaching to groundwater pathway must be evaluated to ensure contaminated soil will not cause future groundwater concentrations to exceed site-specific target levels. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). The water quality inside the plastic water lines is not a criteria for clearance of this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). If the concentrations of chemicals of concern in a water line exceed the Tier 1 levels for actual receptors for the groundwater ingestion pathway, immediate corrective action must be conducted to eliminate exposure to the water, including but not limited to replacement of the line with an approved nonplastic material.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(9) *Soil to plastic water line pathway assessment.*

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines within ten feet of the soil plume defined to the Tier 1 level. All plastic water lines must be evaluated for this pathway regardless of distance from the source, if the lines are in areas where Tier 1 levels are exceeded.

(2) Potential receptors include all areas where Tier 1 levels are exceeded.

b. Plume definition. The extent of soil contamination must be defined to Tier 1 levels for the chemicals of concern.

c. Target level. The point(s) of exposure include all areas within ten feet of the plastic water line. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). Measurements of water quality inside the plastic water lines may be required, but are not allowed as criteria to clear this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B).

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(10) *Surface water pathway assessment.*

a. Pathway completeness. Unless maximum concentrations are less than the applicable Tier 1 levels, this pathway is complete and must be evaluated under any of the following conditions: (1) there is a designated use surface water within the modeled groundwater plume or the actual plume as provided in 135.10(2)*"f"* and 135.10(2)*"g"*; or (2) any surface water body which failed the Tier 1 visual inspection as provided in 135.9(10).

b. Visual inspection. A visual inspection must be conducted according to 135.9(10)*"c."* If a sheen or residue from a petroleum-regulated substance is present, soil and groundwater sampling must be conducted to identify the source of the release and to define the extent of the contaminant plume to the levels acutely toxic to aquatic life as provided in 567—subrule 61.3(2).

c. Receptor evaluation.

(1) Surface water criteria apply only to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). If the surface water body is a designated use segment and if maximum groundwater concentrations exceed applicable surface water criteria, the extent of contamination must be defined as provided in paragraph *"d."* The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the surface water body because surface water must be protected for low flow conditions. In-stream measurements of concentrations are not allowed as a basis for no further action.

(2) If the visual inspection indicates the presence of a petroleum sheen in a general use segment within 200 feet of the source, as defined in 567—paragraph 61.3(1)*"a,"* the segment must be evaluated as an actual receptor. The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the general use segment.

d. Plume definition. The groundwater plume must be defined to the surface water criteria levels for designated use segment receptors and to the acutely toxic levels for general use segment receptors, with an emphasis between the source and the surface water body.

e. Target levels. Determining target levels for this pathway involves a two-step process.

(1) Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern at the point of compliance. If the modeled concentrations or field data at the point of compliance exceed surface water criteria for designated use segments, an allowable discharge concentration must be calculated. If the projected concentrations and field data at the point of compliance do not exceed surface water criteria, no further action is required to assess this pathway.

(2) The department water quality section will calculate the allowable discharge concentration using information provided by the certified groundwater professional on a department form. Required information includes, at a minimum, the site location and a discharge flow rate calculated according to the department's Tier 2 guidance. The allowable discharge concentration is the target level which must be met adjacent to the surface water body which is the point of compliance.

(3) The target level at the point of exposure/compliance for general use segments subject to evaluation is the acutely toxic levels established by the department under 567—Chapter 61 and 567—subrule 62.8(2). If the modeled concentrations of field data at the point of exposure/compliance exceed the acutely toxic levels, modeling must be used to determine site classifications and corrective action in accordance with 135.12(455B).

f. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) For general use segments, as defined in 567—subrule 61.3(1), if the groundwater professional determines there is no sheen or residue present or if the site is not the source of the sheen or residue or if the sheen does not consist of petroleum-regulated substances, no further action is required for assessment of this pathway. If a petroleum-regulated substance sheen is present, the pathway is high risk and subject to classification in accordance with 135.12(455B).

(2) For designated use segments, as provided in 567—subrules 61.3(1) and 61.3(5), if projected concentrations of chemicals of concern and field data at the point of compliance do not exceed the target level adjacent to the surface water, and the groundwater professional determines there is no sheen or residue present, no further action is required for assessment of this pathway.

g. Corrective action response. Unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). For surface water bodies failing the visual inspection criteria, corrective action must eliminate the sheen and reduce concentrations to below the site specific target level in accordance with 135.12(455B).

135.10(11) *Tier 2 submission and review procedures.*

a. Owners and operators must submit a Tier 2 site cleanup report within 180 days of the date the department approves or is deemed to approve a Tier 1 assessment report under 135.9(12). If the owner or operator has elected to conduct a Tier 2 assessment instead of a Tier 1, or a Tier 2 assessment is required due to the presence of free product under 135.7(5), the Tier 2 site cleanup report must be submitted within 180 days of the date the release was confirmed. The department may establish an alternative schedule for submittal.

b. Site cleanup report completeness and accuracy. A Tier 2 site cleanup report is considered to be complete if it contains all the information and data required by this rule and the department's Tier 2 guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the Tier 2 site assessment and preparation of the report must accompany each Tier 2 site cleanup report with a certification as set out below:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' Tier 2 guidance. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No._____, I certify that this document is complete and accurate as provided in 135.10(11) and meets the applicable requirements of the Tier 2 site cleanup report.

Signature

Date

d. Review. Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed.

e. No action required site classification review. The department will review each Tier 2 site cleanup report which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

f. Upon approval of the Tier 2 site cleanup report or as directed by the department, owners and operators must either implement the corrective action recommendations, including any modifications required by the department, or prepare a Tier 3 site analysis. Owners and operators must monitor, evaluate, and report the results of corrective action activities in accordance with the schedule and on a form or in a format required by the department.

g. The department may, in the interest of minimizing environmental or public health risks and promoting a more effective cleanup, require owners and operators to begin cleanup of soil and groundwater before the Tier 2 site cleanup report is approved.

h. Review of the public water supply receptor risk assessment. Rescinded IAB 3/11/09, effective 4/15/09.

[**ARC 7621B**, IAB 3/11/09, effective 4/15/09]

567—135.11(455B) Tier 3 site assessment policy and procedure.

135.11(1) *General.* Tier 3 site assessment. Unless specifically limited by rule or an imminent hazard exists, an owner or operator may choose to prepare a Tier 3 site assessment as an alternative to completion of a Tier 2 assessment under 135.10(455B) or as an alternative to completion of a corrective action design report under 135.12(455B). Prior to conducting a Tier 3 site assessment, a groundwater professional must submit a work plan to the department for approval. The work plan must contain an evaluation of the specific site conditions which justify the use of a Tier 3 assessment, an outline of the proposed

Tier 3 assessment procedures and reporting format and a method for determining a risk classification consistent with the policies underlying the risk classification system in 135.12(455B). Upon approval, the groundwater professional may implement the assessment plan and submit a report within a reasonable time designated by the department.

135.11(2) *Tier 3 site assessment.* A Tier 3 assessment may include but is not limited to the use of more site-specific or multidimensional models and assessment data, methods for calibrating Tier 2 models to make them more predictive of actual site conditions, and more extensive assessment of receptor construction and vulnerability to contaminant impacts. If use of Tier 2 models is proposed with substitution of other site-specific data (as opposed to the Tier 2 default parameters), the groundwater professional must adequately justify how site-specific data is to be measured and why it is necessary. The groundwater professional must demonstrate that the proposal has a proven applicability to underground storage tank sites or similar conditions or has a strong theoretical basis for applicability and is not biased toward underestimating assessment results. The Tier 3 assessment report shall make a recommendation for site classification as high risk, low risk or no action required, at least two corrective action response technologies and provide justification consistent with the standards and policies underlying risk classification and corrective action response under 135.12(455B) and Iowa Code chapter 455B, Division 4, Part 8.

135.11(3) *Review and submittal.* The department will review the Tier 3 assessment for compliance with the terms of the approved work plan and based on principles consistent with these rules and Iowa Code chapter 455B, Division IV, Part 8. Upon approval of the Tier 3 assessment, the department may require corrective action in accordance with 135.12(455B).

567—135.12(455B) Tier 2 and 3 site classification and corrective action response.

135.12(1) *General.* 1995 Iowa Code section 455B.474(1)*"d"*(2) provides that sites shall be classified as high risk, low risk and no action required. Risk classification is accomplished by comparing actual field data to the concentrations that are predicted by the use of models. Field data must be compared to the simulation model which uses the maximum concentrations at a source and predicts at what levels actual or potential receptors could be impacted in the future. Field data must also be compared to the site-specific target level line which assumes a target level concentration at the point of exposure and is used to predict the reduction in concentration that must be achieved at the source in order to meet the applicable target level at the point of exposure. These models not only predict concentrations at points of exposure or a point of compliance at a source but also predict a distribution of concentrations between the source and the point of exposure which may also be points of compliance. The comparison of field data with these distribution curves primarily is considered for purposes of judging whether the modeled data is reasonably predictive and what measures such as monitoring are prudent to determine the reliability of modeled data and actual field data.

For the soil vapor to enclosed pathway and soil to plastic water line pathways, there are no horizontal transport models to use predicting future impacts. Therefore, for these pathways, sites are classified as high risk, low risk or no action based on specified criteria below and in 135.10(455B).

135.12(2) *High risk classification.* Except as provided below, sites shall be classified as high risk if, for any pathway, any actual field data exceeds the site-specific target level line at any point for an actual receptor.

a. For the soil vapor to enclosed space and soil to plastic water line pathways, sites shall be classified as high risk if the target levels for actual receptors are exceeded as provided in 135.10(7) and 135.10(9).

b. For the soil vapor or groundwater vapor to enclosed space pathways, sites shall be classified as high risk if the explosivity levels at applicable points of compliance are exceeded as provided in 135.10(6) and 135.10(7).

c. Generally, sites are classified as low risk if only potential receptor points of compliance are exceeded. The following is an exception. For the soil leaching to groundwater ingestion pathway for potential receptor conditions, the site shall be classified as high risk if the groundwater concentration(s)

exceeds the groundwater Tier 1 level for potential receptor and the soil concentration exceeds the soil leaching site-specific target level at the source.

135.12(3) *High risk corrective action response.*

a. Objectives. The primary objectives of corrective action in response to a high risk classification are both short- term and long-term. The short-term goal is to eliminate or reduce the risk of exposure at actual receptors which have been or are imminently threatened with exposure above target levels. The longer term goal is to prevent exposure to actual receptors which are not currently impacted or are not imminently threatened with exposure. To achieve these objectives, it is the intent of these rules that concentrations of applicable chemicals of concern be reduced by active remediation to levels below the site-specific target level line at all points between the source(s) and the point(s) of exposure as well as to undertake such interim corrective action as necessary to eliminate or prevent exposure until concentrations below the SSTL line are achieved. If it is shown that concentrations at all applicable points have been reduced to below the SSTL line, the secondary objective is to establish that the field data can be reasonably relied upon to predict future conditions at points of exposure rather than reliance on the modeled data. Reliance on field data is achieved by establishing through monitoring that concentrations within the contaminant plume are steady or declining. Use of institutional control and technological controls may be used to sever pathways or control the risk of receptor impacts.

b. For the soil vapor and soil to plastic water line, these objectives are achieved by active remediation of soil contamination below the target level at the point(s) of exposure or other designated point(s) of compliance using the same measurement methods for receptor evaluation under 135.10(7) and 135.10(9).

c. For a site classified as high risk or reclassified as high risk for the soil leaching to groundwater ingestion pathway, these objectives are achieved by active remediation of soil contamination to reduce the soil concentration to below the site-specific target level at the source.

d. A corrective action design report (CADR) must be submitted by a certified groundwater professional for all high risk sites unless the terms of a corrective action plan are formalized in a memorandum of agreement within a reasonable time frame specified by the department. The CADR must be submitted on a form provided by the department and in accordance with department CADR guidance within 60 days of site classification approval as provided in 135.10(11). The CADR must identify at least two principally applicable corrective action options designed to meet the objectives in 135.12(3), an outline of the projected timetable and critical performance benchmarks, and a specific monitoring proposal designed to verify its effectiveness and must provide sufficient supporting documentation consistent with industry standards that the technology is effective to accomplish site-specific objectives. The CADR must contain an analysis of its cost-effectiveness in relation to other options. The department will review the CADR in accordance with 135.12(9).

e. Interim monitoring. From the time a Tier 2 site cleanup report is submitted and until the department determines a site is classified as no action required, interim monitoring is required at least annually for all sites classified as high risk. Groundwater samples must be taken: (1) from a monitoring well at the maximum source concentration; (2) from a transition well, meaning a monitoring well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level, and between the source(s) and the point(s) of exposure; and (3) from a guard well, meaning a monitoring well between the source(s) and the point(s) of exposure with concentrations below the SSTL line. If a receptor is located within an actual plume contoured to the applicable target level for that receptor, the point of exposure must be monitored. If concentrations at the receptor already exceed the applicable target level for that receptor, corrective actions must be implemented as soon as practicable. Monitoring conducted as part of remediation or as a condition of establishing a no action required classification may be used to the extent it meets these criteria. Soil monitoring is required at least annually for all applicable pathways in accordance with 135.12(5)*"d."* All drinking water wells and non-drinking water wells within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested annually for chemicals of concern. Actual plumes refer to groundwater plumes for all chemicals of concern.

f. Remediation monitoring. Remediation monitoring during operation of a remediation system is required at least four times each year to evaluate effectiveness of the system. A remediation monitoring schedule and plan must be specified in the corrective action design report and approved by the department.

g. Technological controls. The purpose of a technological control is to effectively sever a pathway by use of technologies such that an applicable receptor could not be exposed to chemicals of concern above an applicable target risk level. Technological controls are an acceptable corrective action response either alone or in combination with other remediation systems. The purpose of technological controls may be to control plume migration through use of containment technologies, barriers, etc., both as an interim or permanent corrective action response or to permanently sever a pathway to a receptor. Controls may also be appropriate to treat or control contamination at the point of exposure. Any technological control proposed as a permanent corrective action option without meeting the reduction in contaminant concentrations objectives must establish that the pathway to a receptor will be permanently severed or controlled. The effectiveness of a technological control must be monitored under a department approved plan until concentrations fall below the site-specific target level line or its effectiveness as a permanent response is established, and no adverse effects are created.

h. Following completion of corrective action, the site must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6)*"b."* At any point where an institutional or technological control is implemented and approved by the department, the site may be reclassified as no action required consistent with 135.12(6).

135.12(4) *Low risk classification.* A site shall be classified as low risk if none of the pathways are high risk and if any of the pathways are low risk. A pathway shall be classified low risk if it meets one of the following conditions:

a. For actual and potential receptors, if the modeled data and the actual field data are less than the site-specific target level line, and any of the field data is greater than the simulation line.

b. For potential receptors, if any actual field data exceeds the site-specific target level line at any point.

c. For the soil leaching to groundwater ingestion pathway where modeling predicts that the Tier 1 levels for potential receptors would be exceeded in groundwater at applicable potential receptor points of compliance and the soil concentration exceeds the soil leaching to groundwater site-specific target level but groundwater concentrations are currently below the Tier 1 level for potential receptors, the site shall be initially classified as low risk and subject to monitoring under 135.12(5)*"d"*(2). If at any time during the three-year monitoring period, groundwater concentrations exceed the Tier 1 level for potential receptors, the site shall be classified as high risk requiring soil remediation in accordance with 135.12(3)*"c."*

135.12(5) *Low risk corrective action response.*

a. Purpose. For sites or pathways classified as low risk, the purpose of monitoring is to determine if concentrations are decreasing such that reclassification to no action required may be appropriate or if concentrations are increasing above the site-specific target level line such that reclassification to high risk is appropriate. Monitoring is necessary to evaluate impacts to actual receptors and assess the continued status of potential receptor conditions. Low risk monitoring shall be conducted and reported by a certified groundwater professional.

b. For sites or pathways classified as low risk, provide a best management practices plan. The plan must include maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, are determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil. The plan will also contain a contamination monitoring proposal containing sufficient sampling points to ensure the detection of any significant movement of or increase in contaminant concentration.

c. Groundwater monitoring. For groundwater pathways, samples must be taken at a minimum of once per year: (1) from a monitoring well at the maximum source concentration; (2) a transitional well meaning a well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level and between the source and the receptor; and (3) a

guard well meaning a monitoring well between the source and the point of exposure with concentrations below the SSTL line. (NOTE: Monitoring under this provision may be used to satisfy exit monitoring if it otherwise meets the criteria in 135.12(6).)

d. Soil monitoring.

(1) For the soil vapor to enclosed space pathway potential receptors, soil gas samples must be taken at a minimum of once per year in the area(s) of expected maximum vapor concentrations where an institutional control is not in place.

(2) For the soil leaching to groundwater pathway potential receptors, annual groundwater monitoring is required for a minimum of three years as provided in *"c"* above. If groundwater concentrations are below the applicable SSTL line for all three years and a final soil sample taken from the source shows no significant vertical movement, no further action is required. If groundwater concentrations exceed the applicable SSTL line in any of the three years, corrective action is required to reduce soil concentrations to below the Tier 1 levels for soil leaching to groundwater. Therefore, annual monitoring of soil is not applicable.

(3) For the soil to plastic water line pathway potential receptors, notification of the utility company is required. Notification will result in reclassification to no action required. Therefore, annual monitoring of soil is not applicable.

e. Receptors must be evaluated at least annually to ensure no actual or modeled data are above the site-specific target level line for any actual receptors. Potential receptor areas of concern must be evaluated at least annually and the presence of no actual receptors confirmed. If actual receptors are present or reasonably expected to be brought into existence, the owner or operator must report this fact to the department as soon as practicable. Annual monitoring which also meets the exit criteria under 135.12(6) may be used for that purpose.

f. The site or pathway must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6)*"b."* If concentrations for actual receptors increase above the site-specific target level line or potential receptor status changes to actual receptor status, the site must be reclassified as high risk and further corrective action required in accordance with 135.12(3).

135.12(6) *No action required classification.* A site shall be classified as no action required if all of the pathways are classified as no action required as provided below:

a. Soil pathways shall be classified as no action required if samples are less than the applicable target levels as defined for each pathway and confirmational sampling requirements have been met.

b. For initial classification, groundwater pathways shall be classified as no action required if the field data is below the site-specific target level line and all field data is at or less than the simulation line, and confirmation monitoring has been completed successfully. Confirmation sampling for groundwater and soil is a second sample which confirms the no action required criteria.

c. For reclassification from high or low risk, a pathway shall be classified as no action required if all field data is below the site-specific target level line and if exit monitoring criteria have been met. Exit monitoring criteria means the three most recent consecutive groundwater samples from all monitoring wells must show a steady or declining trend and the most recent samples are below the site-specific target level line. Other criteria include the following: The first of the three samples for the source well and transition well must be more than detection limits; concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

d. Confirmation sampling for soil gas and indoor vapor. For the enclosed space pathways, confirmation sampling is required to reasonably establish that the soil gas and indoor vapor samples represent the highest expected levels. A groundwater professional must obtain two samples taken at least two weeks apart. One of the samples must be taken during a seasonal period of lowest groundwater elevation and soil gas samples must be taken below the frost line.

e. Upon site classification as no action required, all groundwater monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49 unless the department requires selected wells to be maintained or written approval to maintain the well is obtained by the department.

135.12(7) *Reclassification.* Any site or pathway which is classified as high risk may be reclassified to low risk if in the course of corrective action the criteria for low risk classification are established. Any site or pathway which is classified as low risk may be reclassified to high risk if in the course of monitoring the conditions for high risk classification are established. Sites subject to department-approved institutional or technological controls are classified as no action required if all other criteria for no action required classification are satisfied.

135.12(8) *Use of institutional and technological controls.*

a. Purpose. The purpose of an institutional control is to restrict access to or use of property such that an applicable receptor could not be exposed to chemicals of concern for as long as the target level is exceeded at applicable points of exposure and compliance. Institutional controls include:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. An environmental covenant as provided in 2005 Iowa Code Supplement section 455B.474(1)*"f"*(4)(f) and in accordance with the provisions of 2005 Iowa Code Supplement chapter 455I and 567—Chapter 14;
5. Any other institutional control the owner or operator can reasonably demonstrate to the department will reduce the risk from a release throughout the period necessary to ensure that no applicable target level is likely to be exceeded.

b. Modification or termination of institutional and technological controls. At a point when the department determines that an institutional or technological control has been removed or is no longer effective for the purpose intended, regardless of the issuance of a no further action certification or previous site classification, it may require owners and operators to undertake such reevaluation of the site conditions as necessary to determine an appropriate site classification and corrective action response. If the owner or operator is in control of the affected property, the department may require reimplementation of the institutional or technological control or may require a Tier 2 assessment of the affected pathway(s) be conducted to reevaluate the site conditions and determine alternative corrective action response. An owner or operator subject to an institutional or technological control may request modification or termination of the control by conducting a Tier 2 assessment of the affected pathway or conduct such other assessment as required by the department to establish that the control is no longer required given current site conditions.

c. If the owner or operator is not in control of the affected property or cannot obtain control and the party in control refuses to continue implementation of an institutional control, the department may require the owner or operator to take such legal action as available to enforce institution of the control or may require the owner or operator to undertake a Tier 2 assessment to determine site classification and an alternative corrective action response. If a person in control of the affected property appears to be contractually obligated to maintain an institutional or technological control, the department may, but is not required to, attempt enforcement of the contractual obligation as an alternative to requiring corrective action by the owner or operator.

d. If a site is classified no action required, subject to the existence of an institutional control or technological control, the holder of the fee interest in the real estate subject to the institutional control or technological control may request, at any time, that the department terminate the institutional control or technological control requirement. The department shall terminate the requirement for an institutional control if the holder demonstrates by completion of a Tier 2 assessment of the applicable pathway or other assessment as required by the department that the site conditions warranting the control no longer exist and that the site or pathway has met exit criteria for no action required classification under 135.12(6).

135.12(9) *Corrective action design report submission and review procedures.*

a. Owners and operators must submit a corrective action design report (CADR) within 60 days of the date the department approves or is deemed to approve a Tier 2 assessment report under 135.10(11) or a Tier 3 assessment is to be conducted. The department may establish an alternative schedule for submittal. As an alternative to submitting a CADR, owners or operators may participate in a corrective action

meeting process to develop a corrective action plan which would be incorporated into a memorandum of agreement or other written agreement approved by the department. Owners or operators shall implement the terms of an approved CADR, memorandum of agreement or other corrective action plan agreement.

b. Corrective action design report completeness and accuracy. A CADR is considered to be complete if it contains all the information and data required by this rule and the department's guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the CADR must provide the following certification with the CADR:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' guidance and specifications for corrective action design reports. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No._____, I certify that this document is complete and accurate as provided in 135.12(9) and meets the applicable requirements of the corrective action design report, and that the recommended corrective action can reasonably be expected to meet its stated objectives.

Signature

Date

d. Review. Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed. Owners or operators who fail to implement actions or meet the activity schedule in a memorandum of agreement resulting from a corrective action meeting or other written corrective action plan agreement or who fail to implement the actions or schedule outlined in an approved CADR are subject to legal action.

e. No action required site classification review. The department will review each CADR which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.12(10) *Monitoring certificates and no further action certificates.*

a. Monitoring certificate. The department of natural resources will issue a monitoring certificate to the owner or operator of an underground storage tank from which a release has occurred, the current property owner, or other responsible party who has undertaken the corrective action warranting issuance of the certificate. Sites classified as low risk or sites classified as high risk/monitoring shall be eligible for a monitoring certificate. The monitoring certificate will be valid until the site is reclassified to a high risk requiring active remediation or no action required site. A site which has been issued a monitoring certificate shall not be eligible to receive a certificate evidencing completion of remediation until the site is reclassified as no action required. The monitoring certificate will be invalidated and the site reclassified to high risk if it is determined by the department that the owner of the site is not in compliance with the requirements specified in the monitoring certificate.

b. No further action certificate. The department will issue a no further action certificate to an owner or operator of an underground storage tank from which a release has occurred, the current property owner or other responsible party who has undertaken the corrective action warranting classification of the site as no action required. The person requesting the certificate shall provide the department with an accurate legal description of the property on which the underground storage tanks are or were formerly located. The following conditions apply:

(1) The site has been determined by a certified groundwater professional to not present an unreasonable risk to the public health and safety or the environment;

(2) A person issued the certificate or a subsequent purchaser of the site cannot be required to perform further corrective action solely because action standards are changed at a later date. Action standards refer to applicable site-specific standards under this rule;

(3) The certificate shall not prevent the department from ordering remediation of a new release or a release of a regulated substance from an unregulated tank;

(4) The certificate will not constitute a warranty of any kind to any person as to the condition, marketability or value of the described property;

(5) The certificate shall reflect any institutional control utilized to ensure compliance with any applicable Tier 2 level; and may include a notation that the classification is based on the fact that designated potential receptors are not in existence;

(6) The certificate shall be in a form which is recordable in accordance with Iowa Code section 558.1 et seq. and substantially in the form as provided in Appendix C.

c. The department shall modify any issued no further action certificates containing institutional controls once the owner, operator or their successor or assign has demonstrated that the institutional control is no longer necessary to meet the applicable Tier 2 level as provided in 135.12(10).

135.12(11) *Expedited corrective action.* An owner, operator or responsible party of a site at which a release of regulated substance is suspected to have occurred may carry out corrective actions at the site so long as the department receives notice of the expedited cleanup activities within 30 calendar days of their commencement; the owner, operator, or responsible party complies with the provisions of these rules; and the corrective action does not include active treatment of groundwater other than:

a. As previously approved by the department; or

b. Free product recovery pursuant to subrule 135.7(5).

c. Soil excavation. When undertaking excavation of contaminated soils, adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base. The owner or operator must maintain adequate records of the excavation area to document compliance with this procedure unless submitted to the department and must provide it to the department upon request.

567—135.13(455B) Public participation.

135.13(1) For each confirmed release that is classified as high or low risk, the department must provide notice to the public by means designated to reach those members of the public directly affected by the release and the recommended corrective action response. This notice may include, but is not limited to, public notice in local newspapers, block advertisements, public service announcements, publication in a state register, letters to individual households, or personal contacts by the staff.

135.13(2) The department must ensure site release information and decisions concerning the Tier 1 assessment report, Tier 2 and Tier 3 site cleanup reports are made available to the public for inspection upon request.

135.13(3) Before approving the Tier 2 or Tier 3 site cleanup report, the department may hold a public meeting to consider comments on the proposed corrective action response if there is sufficient public interest, or for any other reason.

135.13(4) The department must give a public notice that complies with subrule 135.13(1) above if the implementation of the approved Tier 2 or Tier 3 site cleanup report does not achieve the established cleanup levels in the report and the termination of that report is under consideration by the department.

567—135.14(455B) Action levels. The following corrective action levels apply to petroleum regulated substances as regulated by this chapter. These action levels shall be used to determine if further corrective action under 135.6(455B) through 135.12(455B) or 135.15(455B) is required as the result of tank closure sampling under 135.15(3) or other analytical results submitted to the department. The contaminant concentrations must be determined by laboratory analysis as stated in 135.16(455B). Final

cleanup determination is not limited to these contaminants. The contamination corrective action levels are:

	Soil (mg/kg)	Groundwater (ug/L)
Benzene	0.54	5
Toluene	42	1,000
Ethylbenzene	15	700
Xylenes	No limit	10,000
Total Extractable Hydrocarbons	3,800	1,200

567—135.15(455B) Out-of-service UST systems and closure.

135.15(1) *Temporary closure.*

a. When a UST system is temporarily closed, owners and operators must continue operation and maintenance of corrosion protection in accordance with 135.4(2), any release detection in accordance with rule 135.5(455B), and financial responsibility in accordance with 567—Chapter 136. Rules 135.6(455B) to 135.12(455B) must be complied with if a release is suspected or confirmed. However, release detection is not required as long as the UST system is empty. The UST system is empty when all materials have been removed using commonly employed practices so that no more than 2.5 centimeters (1 inch) of residue, or 0.3 percent by weight of the total capacity of the UST system, remain in the system.

b. When a UST system is temporarily closed for three months or more, owners and operators must notify the department in writing of the temporary closure and comply with the following requirements:

(1) Leave vent lines open and functioning; and

(2) Cap and secure all other lines, pumps, accesses, and ancillary equipment.

c. When a UST system is temporarily closed for more than 12 months, owners and operators must return the tank tags and permanently close the UST system if it does not meet either the performance standards in 135.3(1) for new UST systems or the upgrading requirements in 135.3(2), except that the spill and overfill equipment requirements do not have to be met. Owners and operators must permanently close the substandard UST systems at the end of this 12-month period in accordance with 135.15(2) to 135.15(5), unless the department provides an extension of the 12-month temporary closure period. Owners and operators must complete a site assessment in accordance with 135.15(3) before such an extension can be applied for.

135.15(2) *Permanent closure and changes-in-service.*

a. At least 30 days before beginning either permanent closure or a change-in-service under paragraphs *"b"* and *"c"* below, owners and operators must notify the department of their intent to permanently close or make the change-in-service. An owner or operator must seek prior approval to permanently close a tank in a time frame shorter than the 30-day notice. The required assessment of the excavation zone under 135.15(3) must be performed after notifying the department but before completion of the permanent closure or a change-in-service.

b. To permanently close a tank or piping, owners and operators must empty and clean them by removing all liquids and accumulated sludge. All tanks taken out of service permanently must also be either removed from the ground or filled with an inert solid material. Piping must either be removed from the ground or have the ends plugged with an inert solid material.

When permanently closing a tank by filling with inert solid material, the tank may not be filled until a closure report is approved by the department. The tank must be filled within 30 days after department approval. The owner and operator must notify the department within 15 days after filling the tank with inert solid material.

c. Continued use of a UST system to store a nonregulated substance is considered a change-in-service. Before a change-in-service, owners and operators must empty and clean the tank by removing all liquid and accumulated sludge and conduct a site assessment in accordance with 135.15(3).

d. Permanent closure procedures must be followed in the replacement of tanks or piping. Notification must be made using DNR Form 542-1308, "Notification of Tank Closure or Change-in-Service." The form must include the date scheduled for the closure. Oral confirmation of the closure date must be given to the DNR field office 24 hours prior to the actual closure. The required assessment of the excavation zone under 139.15(3) must be performed after notifying the department but before completion of the permanent closure or change-in-service.

NOTE: The following cleaning and closure procedures may be used to comply with subrule 135.15(2): American Petroleum Institute Recommended Practice 1604, "Removal and Disposal of Used Underground Petroleum Storage Tanks"; American Petroleum Institute Publication 2015, "Cleaning Petroleum Storage Tanks"; American Petroleum Institute Recommended Practice 1631, "Interior Lining of Underground Storage Tanks," may be used as guidance for compliance with this subrule; and the National Institute for Occupational Safety and Health "Criteria for a Recommended Standard . . . Working in Confined Space" may be used as guidance for conducting safe closure procedures at some hazardous substance tanks.

135.15(3) *Assessing the site at closure or change-in-service.*

a. Before permanent closure or a change-in-service is completed, owners or operators must measure for the presence of a release where contamination is most likely to be present at the UST site. This soil and groundwater closure investigation must be conducted or supervised by a groundwater professional certified under 567—Chapter 134, Part A, unless the department in its discretion grants an exemption and provides direct supervision of the closure investigation. In selecting the sample types, sample locations, and measurement methods, owners and operators must consider the method of closure, the nature of the stored substance, the type of backfill, the depth to groundwater, and other factors appropriate for identifying the presence of a release.

At UST sites with a history of petroleum storage, soil and groundwater samples shall in every case be analyzed for benzene, toluene, ethylbenzene, and xylenes (BTEX) with each compound reported separately in accordance with 135.16(455B). If there has been a history or suspected history of petroleum storage other than gasoline or gasoline blends (i.e., all grades of diesel fuels, fuel oil, kerosene, oil and mineral spirits), or such storage history is unknown or uncertain, soil and groundwater samples shall also be analyzed for total extractable hydrocarbons in accordance with 135.16(455B).

All such samples shall be collected separately and shipped to a laboratory certified under 567—Chapter 42, Part C, within 72 hours of collection. Samples shall be refrigerated and protected from freezing during shipment to the laboratory.

When a UST is removed from an area of confirmed contamination, the department may waive closure sampling if written documentation is submitted with the closure notification. Documentation should include laboratory analytical reports and a site map showing tank and piping locations along with contamination plume and sampling locations.

b. For all permanent tank and piping closures or changes-in-service, at least one water sample must be taken from the first saturated groundwater zone via a monitoring well or borehole except as provided in paragraph *"g."* The well or borehole must be located downgradient from and as close as possible to the excavation but no farther away than 20 feet.

If, however, the first saturated groundwater zone is not encountered within 10 feet below the lowest elevation of the tank excavation, the requirement for groundwater sampling shall not apply unless:

(1) Sands or highly permeable soils are encountered within 10 feet below the lowest level of the tank excavation which together with the underlying geology would, in the judgment of the department, pose the reasonable possibility that contamination may have reached groundwaters deeper than 10 feet below the lowest level of the tank excavation. The method of determining highly permeable soil is found in the departmental guidance documents entitled "Underground Storage Tank Closure Procedures for Tank and Piping Removal" and "Underground Storage Tank Closure for Filling in Place."

(2) Indications of potential groundwater contamination, including petroleum products in utility lines, petroleum products in private wells, petroleum product vapors in basements or other structures, occur in the area of the tank installation undergoing closure or change-in-service.

c. For permanent closure by tank removal, the departmental guidance document entitled "Underground Storage Tank Closure Procedures for Tank and Piping Removal" must be followed. The minimum number of soil samples that must be taken depends on the tank size and length of product piping. Samples must be taken at a depth of 1 to 2 feet beneath the tank fill area below the base of the tank along the tank's centerline. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping.

If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

If contamination is suspected or found in any area within the excavation (i.e., sidewall or bottom), a soil sample must be taken at that location.

The numbers of samples required for tanks are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location on Centerline
1,000 or less	1	center of tank
1,001 - 8,000	2	1/3 from ends
8,001 - 30,000	3	5 feet from ends and at center of tank
30,001 - 40,000	4	5 and 15 feet from ends
40,001 and more	5	5 and 15 feet from ends and at center of tank

d. For closing a tank in place by filling with an inert solid material or for a change-in-service, the departmental guidance document entitled "Underground Storage Tank Closure for Filling in Place" must be followed. The minimum number of soil borings required for sampling depends on the size of the tank and the length of the product piping. Soil samples must be taken within 5 feet of the sides and ends of the tank at a depth of 2 to 4 feet below the base of the tank, but outside the backfill material, at equal intervals around the tank. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping. If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

The minimum numbers of soil borings and samples required are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location of Samples
6,000 or less	4	1 each end and each side
6,001 - 12,000	6	1 each end and 2 each side
12,001 or more	8	1 each end and 3 each side

e. A closure report must be submitted to the department within 45 days of the tank removal or sampling for a closure in place. The report must include all laboratory analytical reports, soil boring and well or borehole construction details and stratigraphic logs, and a dimensional drawing showing location and depth of all tanks, piping, sampling, and wells or boreholes, and contaminated soil encountered. The tank tags must be returned with the closure report.

f. The requirements of this subrule are satisfied if one of the external release detection methods allowed in 135.5(4)*"e"* and *"f"* is operating in accordance with the requirements in 135.5(4) at the time of closure and indicates no release has occurred.

g. If contaminated soils, contaminated groundwater, or free product as a liquid or vapor is discovered during the site assessment or by any other manner, contact the department in accordance with 135.6(1). Normal closure procedures no longer apply. Owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

Identification of free product requires immediate response in accordance with 135.7(5). If contamination appears extensive or the groundwater is known to be contaminated, a full assessment of the contamination will be required. When a full assessment is required or anticipated, collection of the

required closure samples is not required. If contamination appears limited to soils, overexcavation of the contaminated soils in accordance with 135.15(4) may be allowed at the time of closure.

135.15(4) *Overexcavation of contaminated soils at closure.*

a. If contaminated soils are discovered while assessing a site at closure in accordance with 135.15(3), owners and operators may overexcavate up to one foot of the contaminated soils surrounding the tank pit. The contamination and overexcavation must be reported to the department in accordance with the requirements of 135.6(4)*"a"* prior to backfilling the excavation. If excavation is limited to one foot of contaminated soils, a soil sample shall be taken and laboratory analyzed in accordance with 135.16(455B) from the area showing the greatest contamination. Any overexcavation of contaminated soils beyond one foot of contaminated soils is considered expedited corrective action and must be conducted by a certified groundwater professional in accordance with the procedures in 135.12(11).

b. Excavated contaminated soils must be properly disposed in accordance with 567—Chapters 100, 101, 102, 120, and 121, Iowa Administrative Code.

c. A report must be submitted to the department within 30 days of completion of the laboratory analysis. The report must include the requirements of 135.15(3)*"e"* and a dimensional drawing showing the depth and area of the excavation prior to and after overexcavation. The area of contamination must be shown.

135.15(5) *Applicability to previously closed UST systems.* When directed by the department, the owner and operator of a UST system permanently closed before October 24, 1988, must assess the excavation zone and close the UST system in accordance with this rule if releases from the UST may, in the judgment of the department, pose a current or potential threat to human health and the environment.

135.15(6) *Closure records.* Owners and operators must maintain records in accordance with 135.4(5) that are capable of demonstrating compliance with closure requirements under this rule. The results of the excavation zone assessment required in 135.15(3) must be maintained for at least three years after completion of permanent closure or change-in-service in one of the following ways:

a. By the owners and operators who took the UST system out of service;

b. By the current owners and operators of the UST system site; or

c. By mailing these records to the department if they cannot be maintained at the closed facility.

135.15(7) *Applicability to pre-1974 USTs.* The closure provisions of rule 135.15(455B) are not applicable to USTs which have been out of operation as of January 1, 1974. For purposes of this subrule, out of operation means that no regulated substance has been deposited into or dispensed from the tanks and that the tanks do not currently contain an accumulation of regulated substances other than a de minimus amount as provided in 135.15(1)*"a."*

Owners and operators or other interested parties are not required to submit documentation that USTs meet the exemption conditions and may rely on this subrule as guidance. However, should a question arise as to whether USTs meet the exemption, or owners and operators or other interested parties request acknowledgment by the department that USTs are exempt, they must submit an affidavit on a form provided by the department. The affiant must certify that based on a reasonable investigation and to the best of the affiant's knowledge, the USTs were taken out of operation prior to January 1, 1974, the USTs have not contained a regulated substance since January 1, 1974, and the USTs do not currently contain an accumulation of regulated substances.

If the department has a reasonable basis to suspect a release has occurred, the release investigation and confirmation steps of subrule 135.8(1) and the corrective action requirements as provided in 135.7(455B) to 135.8(455B) shall apply.

[**ARC 8124B**, IAB 9/9/09, effective 10/14/09]

567—135.16(455B) Laboratory analytical methods for petroleum contamination of soil and water.

135.16(1) *General.* When having soil or water analyzed for petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83. In addition they must ensure that all soil and groundwater samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83, for UST petroleum analyses. This

rule provides acceptable analytical procedures for petroleum substances and required information that must be provided in all laboratory reports.

135.16(2) *Laboratory report.* All laboratory reports must contain the following information:

a. Laboratory name, address, telephone number and Iowa laboratory certification number. If analytical work is subcontracted to another laboratory, the analytical report from the certified lab which analyzed the sample must be submitted and include the information required in this subrule.

b. Medium sampled (soil, water).

c. Client submitting sample (name, address, telephone number).

d. Sample collector (name, telephone number).

e. UST site address.

f. Clients sample location identifier.

g. Date sample was collected.

h. Date sample was received at laboratory.

i. Date sample was analyzed.

j. Results of analyses and units of measure.

k. Detection limits.

l. Methods used in sample analyses (preparation method, sample detection method, and quantitative method).

m. Laboratory sample number.

n. Analyst name.

o. Signature of analyst's supervisor.

p. Condition in which the sample was received at the laboratory and whether it was properly sealed and preserved.

q. Note that analytical results are questionable if a sample exceeded an established holding time or was improperly preserved. (The recommended holding time for properly cooled and sealed petroleum contaminated samples is 14 days, except for water samples containing volatile organic compounds which have a 7-day holding time unless acid-preserved.)

r. Laboratory reports required by this chapter for tank closure investigations under 135.15(455B) and site checks under 135.6(3) or Tier 1 or Tier 2 assessments under 135.9(455B) to 135.11(455B) must include a copy of the chromatograms and associated quantitation reports for the waste oil, diesel and gasoline standard used by the laboratory in analyzing submitted samples. The laboratory analytical report for each sample must state whether the sample tested matches the laboratory standard for waste oil, diesel or gasoline or that the sample cannot be reliably matched with any of these standards. A copy of the chromatograms and associated quantitation reports for only the soil and groundwater samples with the maximum concentrations of BTEX and TEH must be included.

135.16(3) *Analysis of soil and water for high volatile petroleum compounds (i.e., gasoline, benzene, ethylbenzene, toluene, xylene).* Sample preparation and analysis shall be by Method OA-1, "Method for Determination of Volatile Petroleum Hydrocarbons (gasoline)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 5030, 8000, and 8015, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-1 are available from the department.

135.16(4) *Analysis of soil and water for low volatile petroleum hydrocarbon contamination (i.e., all grades of diesel fuel, fuel oil, kerosene, oil, and mineral spirits).* Sample preparation and analysis shall be by Method OA-2, "Determination of Extractable Petroleum Products (and Related Low Volatility Organic Compounds)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 3500, 3510, 3520, 3540, 3550, 8000, and 8100, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-2 are available from the department.

135.16(5) *Analysis of soil gas for volatile petroleum hydrocarbons.* Analysis of soil gas for volatile petroleum hydrocarbons shall be conducted in accordance with the National Institute for Occupational Safety and Health (NIOSH) Method 1501, or a department-approved equivalent method.

567—135.17(455B) Evaluation of ability to pay.

135.17(1) General. The ability to pay guidance procedures referenced in this rule will be used by the department when an owner or operator of an underground storage tank (UST) claims to be financially unable to comply with corrective action requirements under 135.7(455B) to 135.12(455B) or closure investigation requirements under 135.15(455B). If an owner or operator of a regulated UST claims to be financially unable to meet these departmental requirements, that responsible party must provide documentation of the party's finances on forms provided by the department in order for the department to act on the claim of financial inability. The department may request additional financial documentation to verify or supplement reported information.

135.17(2) Individual claims. The financial ability of individual owners and operators of USTs, with or without an active business (including but not limited to sole proprietorships and general partnerships), shall be evaluated using the "Individual Ability to Pay Guidance" document dated June 19, 1992, and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(3) Corporate claims. The financial ability of corporate owners and operators of USTs shall be evaluated using the June 1992 version of "ABEL" developed by the U.S. Environmental Protection Agency and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(4) Federal LUST Trust Fund. The financial ability of owners and operators of USTs shall be evaluated for the purpose of determining if the department is authorized to use Federal LUST Trust Fund moneys as provided in the current cooperative agreement with the U.S. Environmental Protection Agency, Region VII. A determination of financial inability does not create an entitlement or any expectation interest on behalf of an owner or operator that Federal LUST Trust Fund moneys will be used for corrective action at any individual site.

135.17(5) The evaluation of financial ability will also be used by the department in making other administrative planning decisions including but not limited to decisions as to whether to pursue and when to pursue administrative or judicial enforcement of regulatory and statutory duties and the assessment of penalties. A determination of financial inability does not create an entitlement or expectation interest that enforcement actions will be deferred or suspended. The evaluation of this factor is only one of many affecting the department's fully discretionary decisions regarding enforcement options and program planning.

135.17(6) An evaluation of financial inability as provided in this rule does not relieve any owner or operator of legal liability to comply with department rules or Iowa Code chapter 455B or provide a defense to any legal actions to establish liability or enforce compliance.

567—135.18(455B) Transitional rules.

135.18(1) *Transitional rules.* Guidance for implementing these transitional rules is contained in the department's guidance entitled "Transition Policy Statement" dated June 6, 1996.

135.18(2) *Site cleanup reports and corrective action design reports accepted before August 15, 1996.* Any owner or operator who had a site cleanup report or corrective action design report approved by the department before August 15, 1996, may elect to submit a Tier 1 Site Assessment or Tier 2 Site Cleanup Report to the department. If the owner, operator, or responsible party so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 1 Site Assessment or Tier 2 Site Cleanup Report, the owner or operator shall utilize the default parameters set out in subrule 135.18(4) or provide site-specific parameters.

135.18(3) *Site cleanup reports in the process of preparation or review prior to August 15, 1996.* The department will complete a Tier 1 or a Tier 2 risk analysis for any site cleanup report received but not approved by the department by November 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 2 site cleanup report and the owner or operator elects to not complete a Tier 2 site cleanup report the department shall utilize the default

parameters set out in subrule 135.18(4). If the owner or operator wishes that site-specific data, rather than any default parameter, be used, the owner or operator shall notify the department by October 15, 1996, or in accordance with a schedule specified by the department. Following notification, the owner or operator shall be responsible for preparation of the Tier 1 site assessment or Tier 2 site cleanup report.

135.18(4) *Default parameters for use in converting a site cleanup report to a Tier 2 site cleanup report.*

a. As to sites for which the owner or operator has collected and submitted only TPH ("total petroleum hydrocarbons") data regarding soil contamination, TPH levels shall be converted to a risk associated factor by using: (1) previously acquired data regarding benzene, toluene, ethyl benzene, and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene, and xylenes data for the site; or (3) the assumptions that 1 percent of the total petroleum hydrocarbon (TPH) is benzene, 7 percent of the TPH is toluene, 2 percent of the TPH is ethylbenzene, and 8 percent of the TPH is xylenes.

b. As to sites for which the owner or operator has, to date, submitted only TEH ("total extractable hydrocarbons") data regarding soil contamination, TEH levels should be converted to a risk-associated factor by using: (1) previously acquired benzene, toluene, ethylbenzene and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene and xylenes data for the site; or (3) the assumption that 0.004 percent of the TEH is benzene, 0.05 percent of the TEH is toluene, 0.03 percent of the TEH is ethylbenzene and 0.3 percent of the TEH is xylenes. In addition, TEH levels should be compared to the TEH default levels in the Tier 1 Table. If, as of August 15, 1996, only TEH data for soil is available, and it does not exceed Tier 1 levels, additional sampling for TEH in groundwater is not required. Otherwise, groundwater samples must be collected and analyzed for TEH in accordance with 135.8(3).

c. Data required for preparing a Tier 2 site cleanup report shall be taken from the site cleanup report. If the site cleanup report lacks any of the data, site-specific data subsequently obtained may be used. The following assumptions shall be used if no site cleanup report or site-specific data is provided:

(1) If the site cleanup report is unclear as to neighboring land use, assume the land residential land use;

(2) Use the larger resulting default if both TPH and TEH data are available.

(3) For sites with free product gasoline range constituents, the default values in groundwater are 17,500 ug/l for benzene, 3,040 ug/l for ethylbenzene, 37,450 ug/l for toluene and 15,840 ug/l for xylenes. For sites with free product consisting of diesel range constituents, the default values are 370 ug/l benzene, 640 ug/l toluene, 140 ug/l ethylbenzene, 580 ug/l xylenes, and 260 ug/l naphthalene or 130,000 ug/l TEH.

135.18(5) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports accepted before August 6, 2008.* Any owner or operator who had a Tier 2 site cleanup report, Tier 3 report, or corrective action design report approved by the department before August 6, 2008, may elect to submit a Tier 2 site cleanup report using the Appendix B revised model, department-developed software and rules in effect as of August 6, 2008. The owner or operator shall notify the department that the owner or operator wishes to evaluate the leaking underground storage tank site with the Appendix B revised model, software and rules. If the owner or operator so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 6, 2008. If the leaking underground storage tank site is undergoing active remediation, the remediation system shall remain operating until the reevaluation is completed and accepted or as otherwise approved by the department. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model and software and rules in effect prior to August 6, 2008.

135.18(6) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports in the process of preparation with a submittal schedule established prior to August 6, 2008.* The owner or operator shall notify the department that the owner or operator wishes to use the Appendix B revised model and department software and rules in effect as of August 6, 2008, to evaluate the leaking underground storage tank site before submitting the next report, and prior to expiration of the previously established submittal schedule. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model, software and rules existing just prior to August 6, 2008.

135.18(7) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports received by the department but not yet reviewed.* The owner or operator will notify the department within 60 days of August 6, 2008, whether the owner or operator is electing to complete a risk-based corrective action assessment using Appendix B revised model, department software and rules effective as of August 6, 2008, or proceeding with the risk-based corrective action assessment using Appendix B-1 old model and department software and rules existing prior to August 6, 2008. Once a site has been evaluated using the Appendix B revised model, software and rules it can no longer be evaluated with the previous Appendix B-1 old model, software and rules.

567—135.19(455B) Analyzing for methyl tertiary-butyl ether (MTBE) in soil and groundwater samples.

135.19(1) *General.* The objective of analyzing for MTBE is to determine its presence in soil and water samples collected as part of investigation and remediation of contamination at underground storage tank facilities.

135.19(2) *Required MTBE testing.* Soil and water samples must be analyzed for MTBE when collected for risk-based corrective action as required in rules 135.8(455B) through 135.12(455B). These sampling requirements include but are not limited to:

a. Risk-based corrective action (RBCA) evaluations required for Tier 1, Tier 2, and Tier 3 assessments and corrective action design reports.

b. Site monitoring.

c. Site remediation monitoring.

135.19(3) *MTBE testing not required.* Soil and water samples for the following actions are not required to be analyzed for MTBE:

a. Closure sampling under rule 135.15(455B) unless Tier 1 or Tier 2 sampling is being performed.

b. Site checks under subrule 135.7(3) unless Tier 1 or Tier 2 sampling is being performed.

c. If prior analysis at a site under 135.19(2) has not shown MTBE present in soil or groundwater.

d. If the department determines MTBE analysis is no longer needed at a site.

135.19(4) *Reporting.* The analytical data must be submitted in a format prescribed by the department.

135.19(5) *Analytical methods for methyl tertiary-butyl ether (MTBE).* When having soil or water analyzed for MTBE from contamination caused by petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83 for petroleum analyses. In addition, the owners and operators must ensure all soil and water samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83 for petroleum analyses.

a. Sample preparation and analysis shall be by:

(1) GC/MS version of OA-1, "Method for Determination of Volatile Petroleum Hydrocarbons (gasoline)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa; or

(2) U.S. Environmental Protection Agency Method 8260B, SW-846, "Test Methods for Evaluating Solid Waste," Third Edition.

b. Laboratories performing the analyses must run standards for MTBE on a routine basis, and standards for other possible compounds like ethyl tertiary-butyl ether (ETBE), tertiary-amyl methyl ether (TAME), diisopropyl ether (DIPE), and tertiary-butyl alcohol (TBA) to be certain of their identification should they be detected.

c. Laboratories must run a method detection limit study and an initial demonstration of capability for MTBE. These records must be kept on file.

d. The minimum detection level for MTBE in soil is 15 ug/kg. The minimum detection level for MTBE in water is 15 ug/l.

567—135.20(455B) Compliance inspection of UST system.

135.20(1) The owner or operator must have the UST system inspected and an inspection report submitted to the department by a UST compliance inspector certified by the department under

567—Chapter 134. An initial compliance site inspection shall be conducted no later than December 31, 2007. All subsequent compliance site inspections conducted after the compliance site inspection for the 2008-2009 biennial period shall be conducted within 24 months of the prior compliance site inspection. Compliance site inspections must be separated by at least six months.

135.20(2) Compliance inspection requirements. The owner or operator is responsible to ensure the department receives ten days' prior notice by the compliance inspector of the date of a site inspection and the name of the inspector as provided in 567—134.14(455B). The owner and operator must comply with the following as part of the inspection process.

a. Review and respond to the inspection report provided by the certified compliance inspector and complete the corrective actions specified in the compliance inspection report within the specified time frames.

b. Provide all records and documentation required by the certified compliance inspector and this chapter.

c. Upon notification of a suspected release by the certified compliance inspector pursuant to 567—subrule 134.14(1), report the condition to the department and undertake steps to investigate and confirm the suspected release as provided in 567—135.6(455B).

d. Ensure that the compliance inspector completes and submits an electronic inspection form in accordance with 567—134.14(455B).

135.20(3) The owner and operator shall do the following upon receipt of a compliance inspection report as provided in 567—subrule 134.14(1) which finds violations of the department's rules:

a. Take all actions necessary to correct any compliance violations or deficiencies in accordance with this chapter. Corrective action must be taken within the time frame established by rule or, if no time frames are established by rule, within 60 days of receipt of the inspector's report or another reasonable time period approved by the department. The granting of time to remedy a violation does not preclude the department from exercising its discretion to assess penalties for the violation.

b. Within 60 days of receipt of the inspector's report, provide documentation to the compliance inspector that the violation or deficiencies have been corrected.

c. Conduct a follow-up inspection in instances where there are serious problems or a history of repeated violations when required by the department.

135.20(4) Conflict of interest. A compliance site inspection must be conducted by a certified compliance inspector who is not the owner or operator of the UST system being inspected, an employee of the owner or operator of the UST system being inspected, or a person having daily on-site responsibility for the operation and maintenance of the UST system.

[**ARC 8124B**, IAB 9/9/09, effective 10/14/09]

Appendix A - Tier 1 Table, Assumptions, Equations and Parameter Values

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*: Standards in the Diesel column apply to all low volatile petroleum hydorcarbons except waste oil.

Assumptions Used for Iowa Tier 1 Look-Up Table Generation

1. Groundwater ingestion pathway. The maximum contaminant levels (MCLs) were used for Group 1 chemicals. The target risk for carcinogens for actual receptors is 10^{-6} and for potential receptors is 10^{-4}. A hazard quotient of one, and residential exposure and building parameters are assumed.

2. Groundwater vapor to enclosed space pathway. Residential exposure and residential building parameters are assumed; no inhalation reference dose is used for benzene; the capillary fringe is assumed to be the source of groundwater vapor; and the hazard quotient is 1 and target risk for carcinogens is $1x10^{-4}$.

3. Groundwater to plastic water line. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4}.

4. Surface water. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4}, except for toluene which has a chronic level for aquatic life of 1,000 as in the definition for surface water criteria in 567—135.2.

5. Soil leaching to groundwater. This pathway assumes the groundwater will be protected to the same levels as the groundwater ingestion pathway for potential receptors, using residential exposure and a target risk for carcinogens of 10^{-4}.

6. Soil vapor to enclosed space pathway. The target risk for carcinogens is $1x10^{-4}$; the hazard quotient is 1; no inhalation reference dose is used for benzene; residential exposure factors are assumed; and the average of the residential and nonresidential building parameters are assumed.

7. Soil to plastic water line pathway. This pathway uses the soil leaching to groundwater model with nonresidential exposure and a target risk for carcinogens of 10^{-4}

In addition to these assumptions, the equations and parameter values used to generate the Iowa Tier 1 Look-Up Table are described below.

Groundwater Ingestion Equations

Carcinogens:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{TR \times BW \times AT_c \times \frac{365\ days}{year}}{SF_o \times IR_w \times EF \times ED}$$

Noncarcinogens:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{THQ \times RfD_o \times BW \times AT_n \times \frac{365\ days}{year}}{IR_w \times EF \times ED}$$

Soil Leaching to Groundwater Equations

$$RBSL_{sl}\left[\frac{mg}{kg - soil}\right] = \frac{RBSL_w\left[\frac{mg}{L - H_2O}\right]}{LF}$$

$$LF\left[\frac{mg/L - H_2O}{mg/kg - soil}\right] = \frac{\rho_s}{(\theta_{ws} + k_s\rho_s + H\theta_{as})\left(1 + \frac{U\delta}{IW}\right)}$$

Soil Vapor to Enclosed Space Equations

$$RBSL_{sv}\left[\frac{mg}{kg - soil}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right]}{VF_{sv}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{sv}\left[\frac{(mg/m^3 - air)}{(mg/kg - soil)}\right] = \frac{\frac{H\rho_s}{(\theta_{ws} + k_s\rho_s + H\theta_{as})}\left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right]}{1 + \left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right] + \left[\frac{D_s^{eff}/L_s}{\left(D_{crack}^{eff}/L_{crack}\right)\eta}\right]}\left(10^3\ \frac{cm^3 - kg}{m^3 - g}\right)$$

$$D_{crack}^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{acrack}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{wcrack}^{3.33}}{\theta_T^2}$$

$$D_s^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{as}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{ws}^{3.33}}{\theta_T^2}$$

Indoor Air Inhalation Equations

Carcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right] = \frac{TR \times BW \times AT_c \times \frac{365\ days}{year} \times \frac{1000\ \mu g}{mg}}{SF_i \times IR_{air} \times EF \times ED}$$

Noncarcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right] = \frac{THQ \times RfD_i \times BW \times AT_n \times \frac{365}{kdays} \times \frac{1000\ \mu g}{mg}}{IR_{air} \times EF \times ED}$$

Groundwater Vapor to Enclosed Space Equations

$$RBSL_{gw}\left[\frac{mg}{L - H_2O}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right]}{VF_{gw}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{gw}\left[\frac{(mg/m^3 - air)}{(mg/L - H_2O)}\right] = \frac{H\left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right]}{1 + \left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right] + \left[\frac{D_s^{eff}/L_{gw}}{\left(D_{crack}^{eff}/L_{crack}\right)\eta}\right]}\left(\frac{10^3 L}{m^3}\right)$$

Variable Definitions

δ	groundwater mixing zone thickness (cm)
η	areal fraction of cracks in foundation/wall (cm^2-cracks/cm^2-area)
ρ_s	soil bulk density (g/cm^3)
θ_{acrack}	volumetric air content in foundation/wall cracks (cm^3-air/cm^3-soil)
θ_{as}	volumetric air content in vadose zone (cm^3-air/cm^3-soil)
θ_T	total soil porosity (cm^3-voids/cm^3-soil)
θ_{wcrack}	volumetric water content in foundation/wall cracks (cm^3-H_2O/cm^3-soil)
θ_{ws}	volumetric water content in vadose zone (cm^3-H_2O/cm^3-soil)
AT_c	averaging time for carcinogens (years)
AT_n	averaging time for noncarcinogens (years)
BW	body weight (kg)
D^{air}	chemical diffusion coefficient in air (cm^2/s)
D^{wat}	chemical diffusion coefficient in water (cm^2/s)
D^{eff}_{crack}	effective diffusion coefficient through foundation cracks (cm^2/s)
D^{eff}_{s}	effective diffusion coefficient in soil based on vapor-phase concentration (cm^2/s)
ED	exposure duration (years)
EF	exposure frequency (days/year)
ER	enclosed space air exchange rate (s^{-1})
f_{oc}	fraction organic carbon in the soil (kg-C/kg-soil)
H	henry's law constant (L-H_2O)/(L-air)
i	groundwater head gradient (cm/cm)
I	infiltration rate of water through soil (cm/year)
IR_{air}	daily indoor inhalation rate (m^3/day)
IR_w	daily water ingestion rate (L/day)
K	hydraulic conductivity (cm/year)
K_{oc}	carbon-water sorption coefficient (L-H_2O/kg-C)
k_s	soil-water sorption coefficient (L-H_2O/kg-soil), f_{oc} x K_{oc}
L_B	enclosed space volume/infiltration area ratio (cm)
L_{crack}	enclosed space foundation or wall thickness (cm)
LF	leaching factor from soil to groundwater ((mg/L-H_2O)/(mg/kg-soil))
L_{gw}	depth to groundwater from the enclosed space foundation (cm)
L_s	depth to subsurface soil sources from the enclosed space foundation (cm)
$RBSL_{air}$	Risk-Based Screening Level for indoor air ($\mu g/m^3$-air)
$RBSL_{gw}$	Risk-Based Screening Level for vapor from groundwater to enclosed space air inhalation (mg/L-H_2O)
$RBSL_{sl}$	Risk-Based Screening Level for soil leaching to groundwater (mg/kg-soil)
$RBSLs_v$	Risk-Based Screening Level for vapors from soil to enclosed space air inhalation (mg/kg-soil)
$RBSL_w$	Risk-Based Screening Level for groundwater ingestion (mg/L-H_2O)
RfD_i	inhalation chronic reference dose ((mg/(kg-day))
RfD_o	oral chronic reference dose ((mg/(kg-day))
SF_i	inhalation cancer slope factor ((kg-day)/mg)
SF_o	oral cancer slope factor ((kg-day)/mg)
THQ	target hazard quotient for individual constituents (unitless)
TR	target excess individual lifetime cancer risk (unitless)
U	groundwater Darcy velocity (cm/year), U=Ki
VF_{gw}	volatilization factor for vapors from groundwater to enclosed space ((mg/m^3-air)/(mg/L-H_2O))
VF_{sv}	volatilization factor for vapors from soil to enclosed space ((mg/m^3-air)/(mg/kg-soil))
W	width of soil source area parallel to groundwater flow direction (cm)

Soil and Groundwater Parameter Values Used for Iowa Tier 1 Table Generation

Parameter		Iowa Tier 1 Table Value
K	hydraulic conductivity	16060 cm/year
i	groundwater head gradient	0.01 cm/cm
W	width of soil source area parallel to groundwater flow direction	1500 cm
I	infiltration rate of water through soil	7 cm/year
δ	groundwater mixing zone thickness	200 cm
ρ_s	soil bulk density	1.86 g/cm^3
θ_{as}	volumetric air content in vadose zone	0.2 cm^3-air/cm^3-soil
θ_{ws}	volumetric water content in vadose zone	0.1 cm^3-H_2O/cm^3-soil
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2 cm^3-air/cm^3-soil
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1 cm^3-H_2O/cm^3-soil
θ_T	total soil porosity	0.3 cm^3-voids/cm^3-soil
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm
L_{gw}	depth to groundwater from the enclosed space foundation	1 cm

Exposure Factors Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
AT_c (years)	averaging time for carcinogens	70	70
AT_n (years)	averaging time for noncarcinogens	30	25
BW (kg)	body weight	70	70
ED (years)	exposure duration	30	25
EF (days/year)	exposure frequency	350	250
IR_{air} (m^3/day)	daily indoor inhalation rate	15	20
IR_w (L/day)	daily water ingestion rate	2	1
THQ (unitless)	target hazard quotient for individual constituents	1.0	1.0

Building Parameters Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
ER (s^{-1})	enclosed space air exchange rate	0.00014	0.00023
L_B (cm)	enclosed space volume/infiltration area ratio	200	300
L_{crack} (cm)	enclosed space foundation or wall thickness	15	15
η	areal fraction of cracks in foundation/wall	0.01	0.01

Chemical-Specific Parameter Values Used for Iowa Tier 1 Table Generation

Chemical	D^{air} (cm^2/s)	D^{wat} (cm^2/s)	H (L-air/L-water)	log(K_{oc}), L/kg
Benzene	0.093	1.1e-5	0.22	1.58
Toluene	0.085	9.4e-6	0.26	2.13
Ethylbenzene	0.076	8.5e-6	0.32	1.98
Xylenes	0.072	8.5e-6	0.29	2.38
Naphthalene	0.072	9.4e-6	0.049	3.11
Benzo(a)pyrene	0.050	5.8e-6	5.8e-8	5.59
Benz(a)anthracene	0.05	9.0e-6	5.74e-7	6.14
Chrysene	0.025	6.2e-6	4.9e-7	5.30

Saturation Values Used to Determine "NA" for the Iowa Tier 1 Table

Chemical	Solubility in Water (mg/L) S	Saturation in Soil (mg/kg) C_s^{sat}
Benzene	1,750	801
Toluene	535	765
Ethylbenzene	152	159
Xylenes	198	492
Naphthalene	31	401
Benzo(a)pyrene	0.0012	4.69
Benz(a)anthracene	0.014	193.3
Chrysene	0.0028	5.59

The maximum solubility of the pure chemical in water is listed in the table above. The equation below is used to calculate the soil concentration (C_s^{sat}) at which dissolved pore-water and vapor phases become saturated. Tier 1 default values are used in the equation. "NA" (for not applicable) is used in the Tier 1 table when the risk-based value exceeds maximum solubility for water (S) or maximum saturation for soil (C_s^{sat}).

$$C_s^{sat}(\text{mg/kg-soil}) = S/\rho_s \times (H\theta_{as} + \theta_{ws} + k_s \rho_s)$$

Slope Factors and Reference Doses Used for Iowa Tier 1 Table Generation

Chemical	SF_i ((kg-day)/mg)	SF_o ((kg-day)/mg)	RfD_i (mg/(kg-day))	RfD_o (mg/(kg-day))
Benzene	0.029	0.029	—	—
Toluene	—	—	0.114	0.2
Ethylbenzene	—	—	0.286	0.1
Xylenes	—	—	2.0	2.0
Naphthalene	—	—	0.004	0.004
Benzo(a)pyrene	6.1	7.3	—	—
Benz(a)anthracene	0.61	0.73	—	—
Chrysene	0.061	0.073	—	—

Appendix B – Tier 2 Equations and Parameter Values (Revised Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

Equation (1)

$$C(x) = C_s \exp\left(\frac{x_m}{2\alpha_x}\left[1-\sqrt{1+\frac{4\lambda\alpha_x}{u}}\right]\right) erf\left(\frac{S_w}{4\sqrt{\alpha_y x_m}}\right) erf\left(\frac{S_d}{4\sqrt{\alpha_z x_m}}\right)$$

Equation (2)

Where $x_m = ax + bx^c$

The value of X_m is computed from Equation (2), where the values for a, b and c in Equation (2) are given in Table 1.

Table 1. Parameter Values for Equation (2)

Chemical	a	b	c
Benzene	1	0.000000227987	3.929438689
Toluene	1	0.000030701	3.133842393
Ethylbenzene	1	0.0001	2.8
Xylenes	1	0.0	0.0
TEH-Diesel	1	0.000000565	3.625804634
TEH-Waste Oil	1	0.000000565	3.625804634
Naphthalene	1	0	0

Variable definitions

x: distance in the x direction downgradient from the source
erf( ): the error function
C(x): chemical concentration in groundwater at x
C_s: Source concentration in groundwater (groundwater concentration at x=0)
S_w: width of the source (perpendicular to x)
S_d: vertical thickness of the source
u: groundwater velocity (pore water velocity); u=Ki/θe
K: hydraulic conductivity
i: groundwater head gradient
θe: effective porosity
λ: first order decay coefficient, chemical specific
αx, αy, αz: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter		Default Value	Required
ρ_s	soil bulk density	1.86 g/cm^3	option
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ_T	total soil porosity	0.3cm^3-voids/cm^3-soil	option
θ_{as}	volumetric air content in vadose zone	0.2cm^3-air/cm^3-soil	default
θ_{ws}	volumetric water content in vadose zone	0.1cm^3-H_2O/cm^3-soil	default
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2cm^3-air/cm^3-soil	default

Parameter		Default Value	Required
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1cm^3-H_2O/cm^3-soil	default
I	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S_w	width of the source	use procedure specified in 135.10(2)	site-specific
S_d	vertical thickness of the source	3 m	default
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	0.33αx	default
αz	dispersivity in the z direction	0.05αx	default
θe	effective porosity	0.1	default

where u=Ki/θe

First-order Decay Coefficients

Chemical	Default Valueλ (d-1)	Required
Benzene	0.000127441	default
Toluene	0.0000208066	default
Ethylbenzene	0.0	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
TEH-Diesel	0.0000554955	default
TEH-Waste Oil	0.0000554955	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
Lgw	depth to groundwater from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s-1)	enclosed space air exchange rate	0.00014	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s-1)	enclosed space air exchange rate	0.000185 *	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:

Potential Residential: use residential exposure and residential building parameters.

Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that

diesel contains 0.2% napthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Appendix B-1 – Tier 2 Equations and Parameter Values (Old Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

$$C(x) = C_s \exp\left(\frac{x}{2\alpha_x}\left[1-\sqrt{1+\frac{4\lambda\alpha_x}{u}}\right]\right)\operatorname{erf}\left(\frac{S_w}{4\sqrt{\alpha_y x}}\right)\operatorname{erf}\left(\frac{S_d}{4\sqrt{\alpha_z x}}\right)$$

Variable definitions

x: distance in the x direction downgradient from the source
erf( ): the error function
C(x): chemical concentration in groundwater at x
C_s: Source concentration in groundwater (groundwater concentration at x=0)
S_w: width of the source (perpendicular to x)
S_d: vertical thickness of the source
u: groundwater velocity (pore water velocity); u=Ki/θe
K: hydraulic conductivity
i: groundwater head gradient
θe: effective porosity
λ: first-order decay coefficient, chemical specific
αx, αy, αz: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter		Default Value	Required
ρ_s	soil bulk density	1.86 g/cm^3	option
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ_T	total soil porosity	0.3cm^3-voids/cm^3-soil	option
θ_{as}	volumetric air content in vadose zone	0.2cm^3-air/cm^3-soil	default
θ_{ws}	volumetric water content in vadose zone	0.1cm^3-H_2O/cm^3-soil	default
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2cm^3-air/cm^3-soil	default
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1cm^3-H_2O/cm^3-soil	default
I	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S_w	width of the source	use procedure specified in 135.10(2)	site-specific
S_d	vertical thickness of the source	3 m	default
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	$0.33\alpha x$	default
αz	dispersivity in the z direction	$0.05\alpha x$	default
θe	effective porosity	0.1	default

where $u=Ki/\theta e$

First-order Decay Coefficients

Chemical	Default Value λ (d-1)	Required
Benzene	0.0005	default
Toluene	0.0007	default
Ethylbenzene	0.00013	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
Benzo(a)pyrene	0	default
Benz(a)anthracene	0	default
Chrysene	0	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
Lgw	depth to groundwater from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s-1)	enclosed space air exchange rate	0.00014	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s-1)	enclosed space air exchange rate	0.000185 *	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:
Potential Residential: use residential exposure and residential building parameters.
Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that diesel contains 0.2% napthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

APPENDIX C
DECLARATION OF RESTRICTIVE COVENANTS
Rescinded IAB 7/19/06, effective 8/23/06

APPENDIX D
IOWA DEPARTMENT OF NATURAL RESOURCES

NO FURTHER ACTION CERTIFICATE

This document certifies that the referenced underground storage tank site has been classified by the Iowa Department of Natural Resources (IDNR) as "no action required" as provided in the 1995 Iowa Code Supplement 455B.474(1)"h"(1). This certificate may be recorded as provided by law.

ISSUED TO: OWNERS/OPERATORS OF TANKS
DATE OF ISSUANCE:
IDNR FILE REFERENCES: LUST # REGISTRATION #
LEGAL DESCRIPTION OF UNDERGROUND STORAGE TANK SITE:

Issuance of this certificate does not preclude the IDNR from requiring further corrective action due to new releases and is based on the information available to date. The department is precluded from requiring additional corrective action solely because governmental action standards are changed. See 1995 Iowa Code Supplement 455B.474(1)"h"(1).

This certificate does not constitute a warranty or a representation of any kind to any person as to the environmental condition, marketability or value of the above referenced property other than that certification required by 1995 Iowa Code Supplement 455B.474(1)"h".

These rules are intended to implement Iowa Code sections 455B.304, 455B.424 and 455B.474.

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[Editorial change: IAC Supplement 5/5/10]

[1] July 15, 1987, effective date of 135.9(4) delayed 70 days by Administrative Rules Review Committee at its June 1987 meeting.

[2] August 6, 2008, effective date of **ARC 6892B** delayed 70 days by Administrative Rules Review Committee at its July 2008 meeting. At its meeting held October 14, 2008, the Committee delayed until adjournment of the 2009 Session of the General Assembly the following provisions: **567—135.2(455B)**, definition of "Sensitive area"; **135.9(4)"f"**; **135.10(4)"a,"** last sentence: "A public water supply screening and risk assessment must be conducted in accordance with 135.10(4)"f" for this pathway" and **135.10(4)"b,"** last sentence of the first paragraph: "The certified groundwater professional or the department may request additional sampling of drinking water wells and non-drinking water wells as part of its evaluation"; **135.10(4)"f"**; **135.10(11)"h."**

[3] February 17, 2010, effective date of 135.5(1)"e" delayed 70 days by the Administrative Rules Review Committee at its meeting held February 8, 2010. At its meeting held April 13, 2010, the Committee delayed the effective date of 135.5(1)"e" until adjournment of the 2011 Session of the General Assembly.

OBJECTION

At a special meeting held on Monday, February 8, 2010, the Administrative Rules Review Committee voted to object to the provisions of **ARC 8469B**, on the grounds these requirements are beyond the authority delegated to the agency. This filing appeared in the 1/13/2010 issue of the Iowa Administrative Bulletin.

This adopted filing establishes leak detection requirements for unstaffed fueling facilities. It requires in-line leak detection to shut off the pump and stop fuel flow to the dispenser. Discussion at the February 8, 2010, meeting raised several issues involving the number of facilities affected and the cost of the upgrades. The issue was also raised whether the rule exceeded the authority of the agency. Iowa Code §455B.474(10) states, in part, "The rules adopted by the commission under this section shall be consistent with and shall not exceed the requirements of federal regulations…." Since federal regulations do not have specific leak detection requirements for unstaffed fueling facilities, the Committee believes the plain language of §455B.474(10) precludes this rulemaking.

For this reason the Committee members felt the new detection requirements are beyond the authority delegated to the agency.

Objection filed February 12, 2010

MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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653—8.1(147,148,272C) Definitions.

"Board" means the Iowa board of medicine.

"Service charge" means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

653—8.2(147,148,272C) Application and licensure fees for acupuncturists.

8.2(1) *Licensure provisions for acupuncturists.* For licensure provisions for acupuncturists, see 653—Chapter 17, "Licensure of Acupuncturists."

8.2(2) *Fees for acupuncturists.* The following fees apply to licensure for acupuncturists.

a. Initial application fee for licensure as an acupuncturist, $300.

b. Reactivation of application for licensure, $100.

c. Renewal fee for licensure as an acupuncturist, $300.

d. Upon written request and payment of the designated fee, the board shall provide the following information about the status of an acupuncturist's license or acupuncturist's past registration:

(1) Certified statement that verifies the status of licensure or past registration in Iowa that requires the board seal or a letter of good standing, $25.

(2) Verification of the status of licensure or past registration in Iowa that does not require a certified statement or letter, $20.

e. Fee for a duplicate wall certificate or renewal card, $25. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

f. Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, $55. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—8.3(147,148,272C) Examination fees for physicians. The fee for taking the United States Medical Licensing Examination Step 3 administered by the board's designated testing service is the fee established by the Federation of State Medical Boards plus $50. See 653—subrule 9.4(2) for information about the examination.

653—8.4(147,148,272C) Application and licensure fees to practice medicine and surgery or osteopathic medicine and surgery.

8.4(1) Fees for permanent licensure. For provisions for permanent licensure, see 653—Chapter 9, "Permanent Physician Licensure." The following fees shall apply to permanent licensure.

a. Initial licensure, $450 plus the fee for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

b. Reactivation of application for licensure, $150.

c. Renewal of an active license to practice, $550 if renewal is made via paper application or $450 if renewal is made via on-line application, per biennial period or a prorated portion thereof if the current license was issued for a period of less than 24 months.

d. Penalty for failure to renew before expiration, $100 per calendar month after the expiration date of the license up to $200. For example, if the license expired on January 1, a penalty of $100 shall be charged for January and an additional $100, or a total of $200, shall be charged for renewal in February.

e. There is no fee for placing a license on inactive status or allowing a license to become inactive.

f. Reinstatement of a license to practice one year or more after becoming inactive, $500 plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

g. Reinstatement of a license within one year of becoming inactive, $550 except when the license in the most recent license period had been granted for less than 24 months. In that case, the reinstatement fee is prorated according to the date of issuance and the physician's month and year of birth.

8.4(2) Fees for resident physician licensure. For provisions for resident physician licensure, see 653—Chapter 10, "Resident, Special and Temporary Physician Licensure." The following fees apply to resident physician licensure.

a. Application for a resident physician license, $150 plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Extension of a resident physician license, $25.

c. Late fee for extension of a resident physician license, $50, to be paid in addition to the extension fee.

8.4(3) Fees for special physician licensure. For provisions for special physician licensure, see 653—Chapter 10, "Resident, Special and Temporary Physician Licensure." The following fees apply to special physician licensure.

a. Application for a special physician license, $300 plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a special physician license, $200.

8.4(4) Fees for temporary physician licensure. For provisions for temporary physician licensure, see 653—Chapter 10, "Resident, Special and Temporary Physician Licensure." The following fees apply to temporary physician licensure.

a. Application for a temporary physician license, $100 plus the fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

b. Renewal of a temporary physician license, $50.

8.4(5) Fee for photocopy of a licensure application. Fee for a photocopy of a licensure application is $20.

8.4(6) Fee for a duplicate wall certificate or renewal card, $25. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

8.4(7) Fee for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks, $55. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

653—8.5(147,148,272C) Fees for verification of physician licensure and certification of examination scores.

8.5(1) *Verification fees.*

a. Physicians shall use VeriDoc to secure a certified statement that verifies Iowa licensure status for any state medical board that accepts VeriDoc. VeriDoc is accessible at http://www.veridoc.org/. The fee for this service is $40.

b. A physician who needs a certified statement that verifies Iowa licensure status for a state medical board that does not accept verification from VeriDoc shall make a written request for a certified statement with payment of a $40 verification fee to the Iowa Board of Medicine. The Iowa board shall provide a certified statement that verifies Iowa licensure status to the nonaccepting state medical board.

c. The fee for verification of Iowa licensure status that does not require a certified statement or letter is $15.

d. The board shall provide an automated telephone verification service whereby callers can input the licensee's license number or social security number and receive verbally the licensee's current licensure status. There is no fee for this service.

The board shall provide a license number for an individual caller to use in the automated telephone verification service. Businesses that utilize verifications will be required to utilize the automated telephone verification service or the alternative outlined in 8.5(1)*"c."*

8.5(2) *Fees for certification of physician examination scores.* Upon request and payment of the designated fee, the board may provide certification of scores of an examination given by the board

in Iowa as permitted under Iowa Code section 147.21 and 653—paragraph 2.13(2)*"f."* The scores available from the board are those from examinees who took the state-constructed examination.

a. Certified statement of grades attained by examination, $45.

b. Certified statement of grades attained by examination including examination history or additional documentation, $55.

653—8.6(147,148,272C) Public records.

8.6(1) *Public records available at no cost.* The following records are available at no cost to the public:

a. Public action taken by the board against a licensee may be found under the licensee's name on the board's Web site, http://medicalboard.iowa.gov, under "Find A Physician." Public actions are posted on the board's Web site within approximately one week after the board has taken action.

b. Electronic files of press releases, statements of charges, final orders and consent agreements from each board meeting are available within approximately one week after the board has taken action. These files are available on the board's Web site, http://medicalboard.iowa.gov.

8.6(2) *Purchase of public records.* Public records are available according to 653—Chapter 2, "Public Records and Fair Information Practices." Payment made to the Iowa Board of Medicine shall be received in the board office prior to the release of the records.

a. Copies of public records shall be calculated at $.25 per page plus labor. A $16 per hour fee shall be charged for labor in excess of one-quarter hour for searching and copying documents or retrieving and copying information stored electronically. No additional fee shall be charged for delivery of the records by mail or fax. Fax is an option if the requested records are fewer than 30 pages. The board office shall not require payment when the fees for the request would be less than $5 total.

b. Electronic copies of public records delivered by E-mail shall be calculated at $.10 per page; the minimum charge shall be $5. A $16 per hour fee shall be charged for labor in excess of one-quarter hour for searching and copying documents or retrieving and copying information stored electronically. The board office shall not require payment when the fees for the requests would be less than $5 total.

c. Printed copies of press releases, statements of charges, final orders and consent agreements from each board meeting shall be available for an annual subscription fee of $192 or a prorated portion thereof based on the calendar year.

653—8.7(147,148,272C) Purchase of a licensee data list. A data list of all physicians and acupuncturists includes the following information about each licensee: full name, year of birth, mailing address, business telephone number, E-mail address, Iowa county (if applicable), medical school (if applicable), year of graduation from medical school (if applicable), two medical specialties (if available), license issue date, license expiration date, license number, license type, license status, and an indicator of whether the board has taken any public action on the license. The fee for an electronic file of the list is $50. Payment made to the Iowa Board of Medicine shall be received in the board office prior to the release of a list. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

653—8.8(147,148,272C) Returned checks. The board shall charge a fee of $25 for a check returned for any reason. If a license had been issued by the board office based on a check that is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification of the returned check by certified mail, the licensee shall be subject to disciplinary action for noncompliance with board rules.

653—8.9(147,148,272C) Copies of the laws and rules. Copies of laws and rules pertaining to the practice of medicine or acupuncture are available from the board for the following fees.

1. Iowa Code and Iowa Administrative Code access, no fee, available at www.medicalboard.iowa.gov.

2. Printed copies of the Iowa Code chapters that pertain to the practice of medicine or acupuncture, $10.

3. Printed copies of board rules in the Iowa Administrative Code, $10.

653—8.10(147,148,272C) Refunds. Application and licensure fees shall be collected by the board and shall not be refunded except by board action in unusual instances, e.g., documented illness or death of the applicant. The board shall consider the cost of the work completed on the application and the cost of the work to grant a refund in determining the amount of refund to be granted.

653—8.11(17A,147,148,272C) Waiver or variance prohibited. Licensure and examination fees in this chapter are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

653—8.12(8,147,148,272C) Request for reports. The board may request a report from the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank regarding an applicant or licensee. The cost of obtaining the report is included within the fee for initial licensure or licensure reinstatement or renewal. However, that portion of the fee spent to obtain that report shall be considered a repayment receipt as defined in Iowa Code section 8.2.

653—8.13(8,147,148,272C) Monitoring fee. A provision for payment of $100 per quarter to cover the board's expenses in monitoring a licensee's compliance with the settlement agreement may be included in the settlement agreement, and payments shall be considered repayment receipts as defined in Iowa Code section 8.2.

These rules are intended to implement Iowa Code sections 147.11, 147.80, 148.3, 148.5, 148.10, and 148.11.

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CHAPTER 17
LICENSURE OF ACUPUNCTURISTS

653—17.1(148E) Purpose. The licensure of acupuncturists is established to ensure that practitioners are qualified to provide Iowans with safe and healthful care. The provisions of Iowa Code chapters 147, 148E and 272C authorize the board of medicine to establish examination requirements for licensure; evaluate the credentials of applicants for licensure (147.2, 148E.3); grant licenses to qualified applicants (148E.2); institute continuing education requirements (272C.2); investigate complaints and reports alleging that licensed acupuncturists violated statutes and rules governing the practice of acupuncture (147.55, 148E.6); make available participation in the Iowa physician health program (272C.3); and discipline licensed acupuncturists found guilty of infractions as provided in state law and board rules (147.55, 148E.6).

653—17.2(148E) Licensure exceptions. In accordance with Iowa Code section 148E.3, the following rules govern those persons engaged in the practice of acupuncture not otherwise licensed by the state to practice medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatry, or dentistry. A student practicing acupuncture under the direct supervision of a licensed acupuncturist as part of a course of study approved by the board as one that leads to eligibility for licensure is not required to obtain a license.

653—17.3(148E) Definitions.

"Acupuncture" means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

"Applicant" means a person not otherwise authorized to practice acupuncture under Iowa Code section 148E.3 who applies to the board for a license.

"Board" means the board of medicine established in Iowa Code chapter 147.

"Committee" means the license and examination committee of the board with oversight responsibility for administration of the licensure of acupuncturists.

"Department" means the Iowa department of public health.

"Disclosure sheet" means the written information licensed acupuncturists must provide to patients on initial contact.

"Disposable needles" means presterilized needles that are discarded after initial use pursuant to Iowa Code section 148E.5.

"License" means a license issued by the board pursuant to Iowa Code section 148E.2.

"Licensed acupuncturist" or *"licensee"* means a person holding a license to practice acupuncture granted by the board under the provisions of Iowa Code chapter 148E.

"National Commission for the Certification of Acupuncturists" means the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

"Practice of acupuncture" means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medicine concepts.

"Professional development activity (PDA)" means any activity for the purpose of continuing a person's education that is defined and approved by NCCAOM. One PDA point equals one hour of continuing education.

"Service charge" means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.4(147,148E) Eligibility for licensure.

17.4(1) *Eligibility requirements.* To be licensed to practice acupuncture by the board, a person shall meet all of the following requirements:

a. Fulfill all the application requirements, as specified in 17.5(147,148E).

b. Hold current active status as a diplomate in NCCAOM or, after June 1, 2004, hold current active status as a diplomate in acupuncture or oriental medicine from NCCAOM.

c. Demonstrate sufficient knowledge of the English language to understand and be understood by patients and board and committee members.

(1) An applicant who passed the NCCAOM written and practical examination components in English may be presumed to have sufficient proficiency in English.

(2) An applicant who passed NCCAOM written or practical examination components in a language other than English shall pass the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) examinations administered by the Educational Testing Service. A passing score on TSE is a minimum of 50. A passing score on TOEFL is a minimum overall score of 550 on the paper-based TOEFL that was administered on a Friday or Saturday (formerly special or international administration), a minimum overall score of 213 on the computer-administered TOEFL, or a minimum overall score of 79 on the Internet-based examination.

d. Successfully complete a three-year postsecondary training program or acupuncture college program which is accredited by, in candidacy for accreditation by, or which meets the standards of, the National Accreditation Commission for Schools and Colleges of Acupuncture and Oriental Medicine.

e. Successfully complete a course in clean needle technique approved by the NCCAOM.

17.4(2) *Waiver or variance prohibited.* Provisions of this rule are not subject to waiver or variance pursuant to IAC 653—Chapter 3 or any other provision of law.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.5(147,148E) Application requirements.

17.5(1) *Application for licensure.* To apply for a license to practice acupuncture, an applicant shall:

a. Submit the completed application form provided by the board, including required credentials and documents, and a completed fingerprint packet; and

b. Pay a nonrefundable initial application fee of $300; and

c. Pay the fee identified in 653—paragraph 8.2(2)*"f"* for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

17.5(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

a. The applicant's name, date and place of birth, and home address, mailing address and principal business address;

b. A photograph of the applicant suitable for positive identification;

c. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice acupuncture, including license, certificate of registration or certification numbers, date of issuance, and an explanation indicating the basis upon which authorization to practice acupuncture was received;

d. Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories;

e. Full disclosure of any disciplinary action taken against the applicant by, but not limited to, a regulatory authority, educational institution, or health facility in any jurisdiction of the United States, other nations or territories;

f. The NCCAOM score report verification form submitted directly to the board by the NCCAOM;

g. An official statement from NCCAOM that the applicant holds active status as a diplomate in NCCAOM or, after June 1, 2004, an official statement from NCCAOM that the applicant holds active status as a diplomate in acupuncture or oriental medicine;

h. An official statement showing successful completion of a course in clean needle technique approved by the NCCAOM;

i. A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in the practice of acupuncture and provide patients with safe and healthful care;

j. A description of the applicant's clinical acupuncture training, work experience and, where applicable, supporting documentation;

k. An official transcript sent directly from the institution of higher education or acupuncture school attended by the applicant and, if necessary, an English translation of the official transcript;

l. Proof of the applicant's proficiency in the English language, when the applicant has not passed the English version of the NCCAOM written and practical examinations;

m. A copy of the disclosure sheet to be used in practice, as described in 17.5(3); and

n. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

17.5(3) *Disclosure sheet.* Pursuant to Iowa Code section 148E.6, applicants shall also provide a copy of the disclosure sheet to be given to each patient that includes the following information:

a. The name, business address and business telephone number of the acupuncturist;

b. A fee schedule;

c. A listing of the acupuncturist's education, experience, degrees, certificates, or other credentials related to acupuncture awarded by professional acupuncture organizations, the length of time required to obtain degrees or credentials, and experience;

d. A statement indicating any license, certificate, or registration in a health care occupation which was revoked by any local, state, or national health care agency;

e. A statement that the acupuncturist is complying with statutes and with rules adopted by the board, including a statement that only presterilized, disposable needles are used by the acupuncturist;

f. A statement that the practice of acupuncture is regulated by the board; and

g. A statement indicating that a license to practice acupuncture does not authorize a person to practice medicine and surgery in this state, and that the services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice.

17.5(4) *Application cycle.* Applications for initial licensure shall be open for 90 days from the date the application form is received in the board's office.

a. After the 90 days, applicants shall update credentials and submit a nonrefundable reactivation of application fee of $100 unless granted an extension in writing by the committee or the board. The period for requesting reactivation of the application is limited to one year from the date the application form is received by the board.

b. Once the application reactivation period is expired, applicants must reapply and submit a new, nonrefundable initial application fee of $300.

17.5(5) *Applicant responsibilities.* An applicant for licensure to practice acupuncture bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national testing or credentialing organizations, health facilities, and educational institutions providing the information specified in 17.5(2);

b. Providing accurate, up-to-date, and truthful information on the application form including, but not limited to, that specified under 17.5(2) related to prior professional experience, education, training, examination scores, diplomate status, licensure or registration, and disciplinary history; and

c. Submitting English translations of documents in foreign languages bearing the affidavit of the translator certifying that the translation is a true and complete translation of the foreign language original. The applicant shall bear the expense of the translation.

17.5(6) *Licensure application review process.* The process below shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff shall notify the applicant about how to resolve any problems identified by the reviewer.

c. If the final review indicates no questions or concerns regarding the applicant's qualifications for licensure, staff may administratively grant the license. The staff may grant the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and administration and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively grant the license.

(2) If any concern exists, the application shall be referred to the committee.

e. Staff shall refer to the committee for review matters which include but are not limited to: falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a license;

(4) Grant a license under certain terms and conditions or with certain restrictions;

(5) Request that the applicant withdraw the licensure application; or

(6) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) Grant a license;

(4) Grant a license under certain terms and conditions or with certain restrictions;

(5) Request that the applicant withdraw the licensure application; or

(6) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

17.5(7) *Grounds for denial of licensure.* The board, on the recommendation of the committee, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in rule 653—17.4(147,148E) as authorized by Iowa Code section 148E.2 or of this chapter of the board's rules.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148E.8 or in rule 653—17.12(147,148E,272C).

17.5(8) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

17.5(9) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as

the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

17.5(10) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with 653—25.30(17A).

a. License denial hearings are contested cases open to the public.

b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.

c. Evidence supporting the denial of the license may be presented by an assistant attorney general.

d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

e. The board, after a hearing on license denial, may grant or deny the application for licensure. The board shall state the reasons for its decision and may grant the license, grant the license with restrictions, or deny the license. The final decision is a public record.

f. Judicial review of a final order of the board denying licensure, or issuing a license with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

17.5(11) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with 17.5(9), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

17.5(12) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with 17.5(9) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

17.5(13) *Waiver or variance prohibited.* Provisions of this rule are not subject to waiver or variance pursuant to IAC 653—Chapter 3 or any other provision of law.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.6(147,148E) Display of license and disclosure of information to patients.

17.6(1) *Display of license.* Licensed acupuncturists shall display the license issued by the board in a conspicuous place in their primary place of business.

17.6(2) *Approval of the disclosure sheet and time limit for revisions.* Pursuant to Iowa Code section 148E.6, upon issuing a license, the board shall provide notification to the licensee of the approval or rejection of the disclosure sheet to be provided to patients on initial contact submitted subsequent to 17.5(4)*"m."*

a. If rejected, the board shall provide the licensee with a written statement explaining the reasons for rejecting the disclosure sheet submitted and indicating the necessary amendments or revisions.

b. Upon receiving the rejection, the licensee shall submit within 14 days a revised mandatory disclosure sheet to the board for its approval.

17.6(3) *Distribution and retention of disclosure sheet.* The licensee shall distribute the disclosure sheet on initial contact with patients and retain a copy, signed and dated by the patient, for a period of at least five years after termination of the treatment.

653—17.7(147,148E,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148E.2, a license is renewed every two years on November 1 for a fee of $300 with documented evidence that the licensee has completed the 30 hours of continuing education required by the board.

Beginning June 1, 2004, renewal shall require evidence of the licensee's current active status as a diplomate in acupuncture or oriental medicine from NCCAOM.

17.7(1) *Expiration date.* Certificates of licensure to practice acupuncture shall expire on October 31 in even years.

17.7(2) *Prorated fees.* The renewal fee for a license shall be prorated on a monthly basis according to the date of issue.

17.7(3) *Renewal requirements and penalties for late renewal.* Each licensee shall be sent a renewal notice at least 60 days prior to the expiration date.

a. Pursuant to Iowa Code section 147.10, application for renewal shall be made in writing to the board accompanied by the required fee at least 30 days prior to the expiration date.

b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. A $50 penalty shall be assessed for renewal in the grace period, a period up until January 1 when the license lapses if not renewed.

17.7(4) *Inactive license.* Failure of a licensee to renew by January 1 will result in invalidation of the license and the license will become inactive.

a. Licensees are prohibited from engaging in the practice of acupuncture once the license is lapsed.

b. Having an acupuncturist license in lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148E.8.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.8(147,272C) Reinstatement of an inactive license.

17.8(1) *Reinstatement requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reinstatement of a license. Pursuant to Iowa Code section 147.11, applicants for reinstatement shall:

a. Submit a completed application for reinstatement of a license to practice acupuncture that includes:

(1) The applicant's name, home address, mailing address, and principal business address.

(2) Full disclosure of the applicant's involvement in civil litigation related to the practice of acupuncture in any jurisdiction of the United States, other nations or territories.

(3) Full disclosure of any disciplinary action taken against the applicant by, but not limited to, a regulatory authority, educational institution, or health facility in any jurisdiction of the United States, other nations or territories.

(4) A practice history for the period of the lapsed license.

b. Pay $400.

c. Provide evidence of successful completion of 60 PDA points.

d. Provide an official statement from NCCAOM that the applicant holds current active status as a diplomate of NCCAOM. After June 1, 2004, provide an official statement from NCCAOM that the applicant holds active status as a diplomate in acupuncture or oriental medicine.

e. Meet any new requirements instituted since the license lapsed.

17.8(2) *Reinstatement restrictions.* Pursuant to Iowa Code section 272C.3(2)*"d,"* the committee may require a licensee who fails to renew for a period of three years from the expiration date to meet any or all of the following requirements prior to reinstatement of an inactive license:

a. Provide a written statement explaining the reasons for failing to renew;

b. Successfully complete continuing education or retraining programs in areas directly related to the safe and healthful practice of acupuncture deemed appropriate by the board or committee;

c. Appear before the committee or board for an interview.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.9(272C) Continuing education requirements—course approval. Pursuant to Iowa Code section 272C.2, a person licensed to practice acupuncture shall complete 30 PDA points to qualify for license renewal.

1. A licensee may earn from 1 to 15 extra PDA points in a license period that may be carried over for credit in the next license period. A licensee desiring to obtain credit for carryover hours shall report the carryover credit on the renewal application when the credit was earned.

2. It is the responsibility of each licensee to finance the costs of the licensee's PDA points.

653—17.10(147,148E,272C) General provisions.

17.10(1) *Use and disposal of needles.* A licensee shall use only presterilized, disposable needles and shall provide for the disposal of used needles in accordance with the requirements of the department.

17.10(2) *Standard of care.* A licensee shall be held to the same standard of care as persons licensed to practice medicine and surgery or osteopathic medicine and surgery. Pursuant to Iowa Code section 272C.3, any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care in the practice of acupuncture constitutes malpractice and is grounds for the revocation or suspension of a license to practice acupuncture in this state.

17.10(3) *Title.* An acupuncturist licensed under this title may use the words "licensed acupuncturist" or "L.Ac." to connote professional standing after the licensee's name in accordance with Iowa Code section 147.74(18).

17.10(4) *Change of residence.* In accordance with Iowa Code section 147.9, licensees shall notify the board of changes in residence and place of practice within one month of the licensee's making an address change.

17.10(5) *Delegation of responsibilities prohibited.* The licensee shall perform all aspects of acupuncture treatment on a patient. Delegation of responsibility for acupuncture treatment is strictly prohibited.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.11(147,148E,272C) General disciplinary provisions. The board is authorized to take disciplinary action against any licensee who violates the provisions set forth in state law and administrative rules pertaining to the safe and healthful practice of acupuncture. This rule is not subject to waiver or variance pursuant to IAC 653—Chapter 3 or any other provision of law.

17.11(1) *Methods of discipline.* The board may impose any of the following disciplinary sanctions:

a. Revocation of a license;

b. Suspension of a license until further order of the board;

c. Nonrenewal of a license;

d. Restrict permanently or temporarily the performance of specific procedures, methods, acts or techniques;

e. Probation;

f. Additional or remedial education or training;

g. Reexamination;

h. Medical or physical evaluation, or alcohol or drug screening within a specific time frame at a facility or by a practitioner of the board's choice;

i. Civil penalties not to exceed $1,000;

j. Citations and warnings as necessary; and

k. Other sanctions allowed by law as deemed appropriate.

17.11(2) *Discretion of the board.* The board may consider the following factors when determining the nature and severity of the disciplinary sanction to be imposed:

a. The relative seriousness of the violation as it relates to assuring the citizens of Iowa a high standard of professional care.

b. The facts of the particular violation.

c. Any extenuating circumstances or other countervailing considerations.

d. Number of prior violations or complaints.

e. Seriousness of prior violations or complaints.

f. Whether remedial action has been taken.

g. Such other factors as may reflect upon the competency, ethical standards and professional conduct of the licensee.

653—17.12(147,148E,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions set forth in 17.11(1) upon determining that a licensee is guilty of any of the following acts or offenses:

17.12(1) *Fraud in procuring a license.* Fraud in procuring a license is the deliberate distortion of facts or use of deceptive tactics in the application for licensure to practice acupuncture including, but not limited to:

a. Making false or misleading statements in obtaining or seeking to obtain licensure;

b. Failing to disclose by deliberate omission or concealment any information the board deems relevant to the safe and healthful practice of acupuncture pursuant to Iowa Code chapters 147 and 148E;

c. Misrepresenting any fact or deed to meet the application or eligibility requirements established by this chapter; or

d. Filing or attempting to file a false, forged or altered diploma, certificate, affidavit, translated or other official or certified document, including the application form, attesting to the applicant's eligibility for licensure to practice acupuncture in Iowa.

17.12(2) *Professional incompetence.* Professional incompetence includes, but is not limited to:

a. Substantial lack of knowledge or ability to discharge professional obligations within the scope of the acupuncturist's practice;

b. Substantial deviation by the licensee from the standards of learning or skill ordinarily possessed and applied by other acupuncturists when acting in the same or similar circumstances;

c. Failure by an acupuncturist to exercise in a substantial respect the degree of care which is ordinarily exercised by the average acupuncturist when acting in the same or similar circumstances; or

d. Willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of acupuncture.

17.12(3) *Fraud in the practice of acupuncture.* Fraud in the practice of acupuncture includes, but is not limited to, any misleading, deceptive, untrue or fraudulent representation in the practice of acupuncture, made orally or in writing, that is contrary to the acupuncturist's legal or equitable duty, trust or confidence and is deemed by the board to be contrary to good conscience, prejudicial to the public welfare, and potentially injurious to another. Proof of actual injury need not be established.

17.12(4) *Unethical conduct.* The Code of Ethics (2008) prepared and approved by the NCCAOM shall be utilized by the board as guiding principles in the practice of acupuncture in this state. Unethical conduct in the practice of acupuncture includes, but is not limited to:

a. Failing to provide patients with the information required in Iowa Code section 148E.6 or providing false information to patients;

b. Accepting remuneration for referral of patients to other health care professionals;

c. Offering or providing remuneration for the referral of patients, excluding paid advertisements or marketing services;

d. Engaging in sexual activity or genital contact with a patient while acting or purporting to act within the scope of the acupuncture practice, whether or not the patient consented to the sexual activity or genital contact;

e. Disclosing confidential information about a patient without proper authorization; or

f. Abrogating the boundaries of acceptable conduct in the practice of acupuncture established by the profession that the board deems appropriate for ensuring that acupuncturists provide Iowans with safe and healthful care.

17.12(5) *Practice harmful to the public.* Practice harmful or detrimental to the public in the practice of acupuncture includes, but is not limited to:

a. Failing to possess and exercise the degree of skill, learning and care expected of a reasonable, prudent acupuncturist acting in the same or similar circumstances;

b. Practicing acupuncture without reasonable skill and safety as the result of a mental or physical impairment, chemical abuse or chemical dependency;

c. Prescribing, dispensing or administering any controlled substance or prescription medication for human use; or

d. Performing any treatment or healing procedure not authorized in Iowa Code chapter 148E or this chapter.

17.12(6) *Habitual intoxication or addiction.* Habitual intoxication or addiction to the use of drugs includes, but is not limited to, the inability to practice acupuncture with reasonable skill and safety as a result of the excessive use of alcohol, drugs, narcotics, chemicals or other substances on a continuing basis, or the excessive use of the same in a way which may impair the ability to practice acupuncture with reasonable skill and safety.

17.12(7) *Felony conviction.* A felony conviction related to the practice of acupuncture or that affects the ability to practice the profession includes, but is not limited to:

a. Any conviction for any public offense directly related to or associated with the practice of acupuncture that is classified as a felony under the statutes of any jurisdiction of the United States, the United States government, or another nation or its political subdivisions; or

b. Any conviction for a public offense affecting the ability to practice acupuncture that is classified as a felony under the statutes of any jurisdiction of the United States, the United States government, or another nation or its political subdivisions and that involves moral turpitude, civility, honesty, or morals.

A copy of the record of conviction or plea of guilty or nolo contendere shall be conclusive evidence of the felony conviction.

17.12(8) *Misrepresentation of scope of practice by licensees.* Misrepresentation of a licensee's scope of practice includes, but is not limited to, misleading, deceptive or untrue representations about competency, education, training or skill as a licensed acupuncturist or the ability to perform services not authorized under this chapter.

17.12(9) *False advertising.* False advertising is the use of fraudulent, deceptive or improbable statements in information provided to the public. False advertising includes, but is not limited to:

a. Unsubstantiated claims about the licensee's skills or abilities, the healing properties of acupuncture or specific techniques or treatments therein;

b. Presenting words, phrases, or figures which are misleading or likely to be misunderstood by the average person; or

c. Claiming extraordinary skills that are not recognized by the acupuncture profession.

17.12(10) *General grounds.* The board may also take disciplinary action against an acupuncturist for any of the following reasons:

a. Failure to comply with the provisions of Iowa Code chapter 148E or the applicable provisions of Iowa Code chapter 147, or the failure of an acupuncturist to comply with rules adopted by the board pursuant to Iowa Code chapter 148E;

b. Failure to notify the board of any adverse judgment or settlement of a malpractice claim or action within 30 days of the date of the judgment or settlement;

c. Failure to report to the board any acts or omissions of another acupuncturist authorized to practice in Iowa that would constitute grounds for discipline under 17.12(147,148E,272C) within 30 days of the date the acupuncturist initially became aware of the information;

d. Failure to comply with a subpoena issued by the board;

e. Knowingly submitting a false report of continuing education or failing to submit a required continuing education report;

f. Failure to adhere to the disciplinary sanctions imposed upon the acupuncturist by the board; or

g. Violating any of the grounds for revocation or suspension of licensure listed in Iowa Code chapter 147 or 148E.

[**ARC 8707B**, IAB 5/5/10, effective 6/9/10]

653—17.13(272C) Procedure for peer review. Rule 653—24.3(272C) shall apply to peer review procedures in matters related to licensed acupuncturists.

653—17.14(272C) Reporting duties and investigation of reports. 653—Chapters 22 and 24 shall apply to certain reporting responsibilities of licensed acupuncturists and the investigation of malpractice cases involving licensed acupuncturists.

653—17.15(272C) Complaints, immunities and privileged communications. 653—Chapter 24 shall apply to matters relating to licensed acupuncturists.

653—17.16(272C) Confidentiality of investigative files. 653—subrule 24.9(2) shall apply to investigative files relating to licensed acupuncturists.

653—17.17 to **17.28** Reserved.

653—17.29(17A,147,148E,272C) Disciplinary procedures. 653—Chapter 25 shall apply to disciplinary actions against licensed acupuncturists.

653—17.30(147,148E,272C) Waiver or variance prohibited. Fees in this chapter are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

These rules are intended to implement Iowa Code sections 17A.10 to 17A.20, 147.55, 272C.3 to 272C.6, 272C.8 and 272C.9 and Iowa Code chapter 148E as amended by 2000 Iowa Acts, chapter 1053.

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◊ Two or more ARCs

CHAPTER 520
REGULATIONS APPLICABLE TO CARRIERS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 8]

761—520.1(321) Safety and hazardous materials regulations.

520.1(1) *Regulations.*

a. Motor carrier safety regulations. The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 385 and 390-399 (October 1, 2009).

b. Hazardous materials regulations. The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, 2009).

c. Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at http://www.fmcsa.dot.gov.

520.1(2) *Carriers subject to regulations.*

a. Operators of commercial vehicles, as defined in Iowa Code section 321.1, are subject to the Federal Motor Carrier Safety Regulations adopted in this rule unless exempted under Iowa Code section 321.449.

b. Operators of vehicles transporting hazardous materials in commerce are subject to the Federal Hazardous Materials Regulations adopted in this rule unless exempted under Iowa Code section 321.450.

c. Operators of vehicles for hire, designed to transport 7 or more persons, but fewer than 16, including the driver, must comply with 49 CFR Part 395 of the Federal Motor Carrier Safety Regulations. In addition, operators of vehicles for hire designed to transport 7 or more persons, but fewer than 16, including the driver, are not exempt from logbook requirements afforded the 100-air-mile radius driver under 49 CFR 395.1(e). However, the provisions of 49 CFR Part 395 shall not apply to vehicles offered to the public for hire that are used principally in intracity operation and are regulated by local authorities.

520.1(3) *Declaration of knowledge of regulations.* Operators of commercial vehicles who are subject to the regulations adopted in this rule shall at the time of application for authority to operate in Iowa or upon receipt of their Iowa registration declare knowledge of the Federal Motor Carrier Safety Regulations and Federal Hazardous Materials Regulations adopted in this rule.

This rule is intended to implement Iowa Code sections 321.1, 321.449 and 321.450.

[**ARC 7750B**, IAB 5/6/09, effective 6/10/09; **ARC 8720B**, IAB 5/5/10, effective 6/9/10]

761—520.2(321) Definitions. The following definitions apply to the regulations adopted in rule 761—520.1(321):

"Any requirements which impose any restrictions upon a person" as used in Iowa Code section 321.449(6) means the requirements in 49 CFR Parts 391 and 395.

"Driver age qualifications" as used in Iowa Code section 321.449(3) means the age qualifications in 49 CFR 391.11(b)(1).

"Driver qualifications" as used in Iowa Code section 321.449(2) means the driver qualifications in 49 CFR Part 391.

"Farm customer" as used in Iowa Code section 321.450, unnumbered paragraph 3, means a retail consumer residing on a farm or in a rural area or city with a population of 3000 or less.

"Gasoline" as used in Iowa Code section 321.450, first unnumbered paragraph, means leaded gasolines, no-lead gasolines, ethanol and ethanol-blended gasolines, aviation gasolines, number 1 and number 2 fuel oils, diesel fuels, aviation jet fuels and kerosene.

"Hours of service" as used in Iowa Code section 321.449(2) means the hours of service requirements in 49 CFR Part 395.

"Record-keeping requirements" as used in Iowa Code section 321.449(2) means the record-keeping requirements in 49 CFR Part 395.

"Rules adopted under this section concerning physical and medical qualifications" as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, means the regulations in 49 CFR 391.11(b)(4) and 49 CFR Part 391, Subpart E.

"Rules adopted under this section for a driver of a commercial vehicle" as used in Iowa Code section 321.449(4) means the regulations in 49 CFR Parts 391 and 395.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.3(321) Motor carrier safety regulations exemptions.

520.3(1) The following intrastate vehicle operations are exempt from the motor carrier safety regulations concerning inspection in 49 CFR Part 396.17 as adopted in rule 761—520.1(321):

a. Implements of husbandry including nurse tanks as defined in Iowa Code section 321.1.

b. Special mobile equipment (SME) as defined in Iowa Code section 321.1.

c. Unregistered farm trailers as defined in 761—subrule 400.1(3), pursuant to Iowa Code section 321.123.

d. Motor vehicles registered for a gross weight of five tons or less when used by retail dealers or their employees to deliver hazardous materials, fertilizers, petroleum products and pesticides to farm customers.

520.3(2) Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.123, 321.449 and 321.450.

761—520.4(321) Hazardous materials exemptions. These exemptions apply to the regulations adopted in rule 761—520.1(321):

520.4(1) Pursuant to Iowa Code section 321.450, unnumbered paragraph 3, "retail dealers of fertilizers, petroleum products, and pesticides and their employees while delivering fertilizers, petroleum products and pesticides to farm customers within a 100-air-mile radius of their retail place of business" are exempt from 49 CFR 177.804; and, pursuant to Iowa Code section 321.449(4), they are exempt from 49 CFR Parts 391 and 395. However, pursuant to Iowa Code section 321.449, the retail dealers and their employees under the specified conditions are subject to the regulations in 49 CFR Parts 390, 392, 393, 396 and 397.

520.4(2) Rescinded IAB 3/10/99, effective 4/14/99.

This rule is intended to implement Iowa Code section 321.450.

761—520.5(321) Safety fitness.

520.5(1) *New motor carrier safety audits.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform safety audits of new motor carriers and shall have the authority to enter a motor carrier's place of business for the purpose of performing these audits. These audits shall be performed in compliance with 49 CFR Part 385 and shall be completed within 18 months from the day the motor carrier commences business.

520.5(2) *Motor carrier compliance reviews.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform compliance reviews of motor carriers and shall have the authority to enter a motor carrier's place of business for the purpose of performing these compliance reviews. These compliance reviews shall be performed in compliance with 49 CFR Part 385.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.6(321) Out-of-service order. A person shall not operate a commercial vehicle or transport hazardous material in violation of an out-of-service order issued by an Iowa peace officer. An out-of-service order for noncompliance shall be issued when either the vehicle operator is not qualified to operate the vehicle or the vehicle is unsafe to be operated until required repairs are made. The out-of-service order shall be consistent with the North American Uniform Out-of-Service Criteria.

This rule is intended to implement Iowa Code sections 321.3, 321.208A, 321.449, and 321.450.

761—520.7(321) Driver's statement. A "driver" as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, shall carry at all times a notarized statement of employment. The statement shall include the following:

1. The driver's name, address and social security number;

2. The name, address and telephone number of the driver's pre-July 29, 1996, employer;

3. A statement, signed by the pre-July 29, 1996, employer or the employer's authorized representative, that the driver was employed to operate a commercial vehicle only in Iowa; and

4. A statement showing the driver's physical or medical condition existed prior to July 29, 1996.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.8(321) Agricultural operations. The provisions of 49 CFR Part 395.3 shall not apply to drivers transporting agricultural commodities or farm supplies for agricultural purposes in Iowa if such transportation:

1. Is limited to an area within a 100-air-mile radius from the source of the commodities or the distribution point from the farm supplies, and

2. Is conducted only during the time frames of March 15 through June 30 and October 4 through December 14.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

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[1] Effective date of 520.1(1)*"a"* and *"b";* rescission of 520.1(2)*"b";* and 520.3 delayed until adjournment of the 1993 Regular Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 14, 1992; delay lifted by the Committee November 10, 1992.

WORKFORCE DEVELOPMENT DEPARTMENT[871]

[Prior to 9/24/86, see Employment Security[370], renamed Job Service Division[345]
under the "umbrella" of Department of Employment Services by 1986 Iowa Acts, chapter 1245]
[Prior to 3/12/97, see Job Service Division[345],
renamed Department of Workforce Development by 1996 Iowa Acts, chapter 1186]

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CHAPTER 21
UNEMPLOYMENT INSURANCE SERVICES DIVISION

871—21.1(96) Unemployment insurance services division.

21.1(1) The primary responsibility of this division is to administer the provisions of the Iowa employment security law and related federal programs in accordance with pertinent laws, regulations, and policies. Attorneys who report to the administrator of the unemployment insurance services division perform the legal services for the division pursuant to Iowa Code section 96.17 which empowers the division to employ attorneys to represent it and give advice on all matters coming before it in conjunction with the administration of Iowa Code chapter 96. The division administers the payment of job insurance benefits to eligible individuals, determines which employers are subject to the state and federal laws enacted in this area, supervises the collection of taxes from these employers, and oversees a program to control the quality of benefit payment and revenue collection. These functions are performed by the following bureaus:

a. Claims case bureau. The claims case bureau determines the eligibility of individuals claiming unemployment insurance. In addition to the Iowa unemployment insurance benefits, the bureau also processes unemployment insurance for Federal Employees Compensation Act (FECA), Unemployment Insurance for Ex-service Members (UCX), claims for Trade Readjustment Act and Expansion Act (TRA and TEA), Voluntary Shared Work (VSW), and Disaster Unemployment Assistance (DUA). It is also responsible for payments of other special federal unemployment insurance benefits as agreed to by the United States Department of Labor and the state of Iowa.

(1) Claims resolution and consultation section. The claims resolution and consultation section is responsible for screening all employer protests and issuing special investigation reports to the local workforce development centers. This section investigates all labor dispute protests and issues appropriate decisions. This section determines individuals' eligibility on disputed claims for unemployment insurance benefits which are not adjudicated at the local office level. This section reviews decisions that determine which employers will receive charges on claims for unemployment insurance benefits and investigates claims for missing wages. The section also responds to communications involving technical matters related to unemployment insurance and corrects necessary records and database due to subsequent appeal decisions which reverse the prior decision issued on a claim.

(2) Special claims section. The special claims section is responsible for processing claims for FECA, UCX, TRA, VSW, DUA, and any other federal unemployment insurance programs. This section determines eligibility, computes and authorizes payments due, maintains needed records, and makes adjustments or redeterminations as applicable. This section is also responsible for processing initial interstate claims, assisting claimants in calling in their continued claims for payment, notifying employer of claim filing, processing overpayments and underpayments, adjudicating issues, processing interstate appeals, and processing combined wage claims.

b. Benefit control bureau. The benefit control bureau is responsible for overseeing the determination of eligibility for individuals claiming unemployment insurance benefits, processing and adjusting benefit payments, document control, and division support. The functions are performed by two sections.

(1) Information control section. The information control section is responsible for the control and conversion of all paper documents compiled during the normal course of business for unemployment insurance claims and taxes. The section converts paper documents to imaged objects or microfilm copies. The section assigns document control information to each paper document which provides automated electronic workflow routing, document retention criteria, document locating information, and computer updates. The section is also responsible for the retrieval of micrographic documents for internal and external customers. The section prepares documents and computer records for release to the public under subpoena or waiver provisions and collects record processing fees. The section is responsible for the child support intercept program in which unemployment insurance benefits are withheld and paid to the child support recovery unit. The section is responsible for the voluntary income tax withholding program in which state and federal taxes are withheld from unemployment insurance benefits. The section is

responsible for reporting tax withholdings and taxable unemployment insurance benefits to the Internal Revenue Service, Iowa department of revenue, and claimants.

(2) Payment control section. The payment control section is responsible for determining eligibility of individuals for unemployment insurance benefits. The section performs fact-finding interviews with claimants and employers to resolve issues discovered by recording the responses the claimant provides to questions asked in the weekly continued claim certification process. The section allows or denies benefits based on Iowa employment security law and Iowa administrative rules and issues a determination. The section computes and issues overpayment determinations and underpayment supplemental benefit payments due to misreported earnings or eligibility disqualifications. The section is responsible for all overpayment billing activity which results in an overpayment setup or refund, overpayment decision letter, or overpayment billing notice. The section is responsible for overpayment recovery programs which include withholding of Iowa income tax refunds, Iowa lottery prizes, Iowa vendor payments, and the Interstate Reciprocal Overpayment Recovery Arrangement. The section is responsible for the issuance of duplicate benefit payments for lost, stolen, outdated, or returned payments. The section authorizes and issues replacement warrants or direct deposit transactions. The section verifies financial institution corrections of direct deposit routing and account numbers and updates the database records.

c. Tax bureau. The tax bureau is responsible for the maintenance and control of all records of unemployment insurance tax paid by liable employers in the state of Iowa. Taxes collected are deposited in a fund to be subsequently used for benefit payments. The bureau maintains financial records on employers; assigns rates each year to employers; makes all necessary adjustments to ensure proper charging to employers of benefits chargeable to them; maintains records of employer overpayments and refunds; and maintains the necessary contacts with employers' accountants, attorneys, and the general public to ensure the proper and timely submission of all the required reports to the division of unemployment insurance. The bureau is responsible for the collection of delinquent tax contributions, benefit reimbursements, and unpaid interest and penalty assessments from all Iowa employers who file job insurance reports. Staff instigates routine legal actions such as the filing of liens, garnishments, and bankruptcies. Employers are contacted by mail, telephone, or personally to initiate the collection process. The bureau reviews contribution reports against payroll reports for matching totals and verifies the amount of the check against the employer's report. The bureau is responsible for depositing all money received for contribution reports, benefit reimbursements, and interest and penalties with the state treasurer's office. The bureau assigns contribution rates to employers, handles the accounting work on partial changes of ownership, adjusts the amounts owed by employers, and audits the taxable wages reported by the employer in accordance with state and federal requirements. It is the bureau's responsibility to contact Iowa and out-of-state employers who do business in Iowa to establish taxpayers' liability under the law; explain the law's provisions; secure information and make determinations pertaining to new accounts, successorships and terminating tax liability; collect delinquent contributions; give information and assistance to ensure compliance in the preparation of tax reports and in securing refunds of overpaid taxes; conduct investigations on FUTA discrepancy problems, contractor registration issues, business closings, and claimant requests for omitted wage credits; determine employer/employee and independent contractor relationship issues; assist in fraud investigations; conduct payroll and financial audits; and appear as an expert witness at employer liability hearings. The bureau also provides services to other states that request assistance with unemployment insurance enforcement of Iowa-based employers who conduct business in their states. The bureau also assigns all field audit work. Information is entered into the automated system which generates materials to be utilized by the field audit staff in conducting an employer inquiry and audit.

d. Field audit bureaus. Rescinded IAB 5/5/10, effective 6/9/10.

e. Investigation and recovery bureau. The investigation and recovery bureau is responsible for aggressive action to prevent, detect, investigate and penalize fraudulent actions on the part of employing units and individuals claiming unemployment insurance benefits. The bureau also recovers overpayments and files liens and garnishments to assist with recovery of overpayments. The bureau verifies that aliens are entitled to unemployment insurance and investigates and disqualifies those

that are not eligible. The bureau conducts the fictitious employer detection program to discover employers set up for the purpose of fraudulent activities. The bureau also prosecutes violations of the Iowa employment security law including fraudulent receipt of unemployment insurance benefits in conjunction with each county attorney in Iowa. The bureau also investigates and determines whether an unemployment insurance warrant has been forged and whether it should be reissued.

f. *Quality control bureau.* The quality control bureau is responsible for the collection and analysis of data pertaining to both the accuracy of payments as well as the effectiveness of revenue collection processes for the unemployment insurance program. Quality control reports directly to the division administrator as it works to support the development and execution of corrective action plans for the improvement of the program. In addition, quality control is responsible for validation of the unemployment insurance data reports, identification and analysis of risk factors which could threaten the unemployment insurance program, and maintenance of the data processing capabilities to store and transmit various agency-required reports to the federal government.

21.1(2) Reserved.

This rule is intended to implement Iowa Code chapter 96.

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

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CHAPTER 22
EMPLOYER RECORDS AND REPORTS

[Prior to 9/24/86, Employment Security [370] Ch 2]
[Prior to 3/12/97, Job Service Division [345] Ch 2]

871—22.1(96) Records to be kept by the employer.

22.1(1) Each employing unit having employment performed for it shall maintain records to show the information hereinafter indicated. Such records shall be kept in such form and manner that it will be possible from an inspection thereof to obtain the facts necessary to determine what remuneration was made by the employing unit and what remuneration is reportable to the department. Such records shall be open to inspection and be subject to be copied by the department and its authorized representatives at any reasonable time. Such records shall be kept for a period of five years after the calendar year in which the remuneration to which they relate was paid or, if not paid, was due.

22.1(2) Such records shall show with respect to each employee, unless the department has ruled that the particular service does not constitute employment:

a. Name of worker.

b. Social security account number.

c. Date on which employee was hired, rehired, or returned to work after a temporary layoff, and the date separated from work and the reason therefor.

d. Scheduled hours except for workers without a fixed schedule of hours, such as those working outside of the employer's establishment in such a manner that the employer has no definite knowledge of their working hours.

e. Total wages paid for employment in each period and the date of payment. For all pay periods ending in each quarter show separately: money wages, the cash value of other remuneration such as any special payment for services such as wages in lieu of notice, bonuses, gifts, prizes, and the nature of payments such as accounts paid to employees as allowance or reimbursement for traveling and other business expenses, and the amounts of such expenditures actually incurred and accounted for by the employees.

f. The state or states in which the services are performed; and if any of such services are performed outside of this state and are not incidental to the service within the state, the base of operations (or if there is no base of operations then the place from which such services are directed or controlled) and the residence (by state), and the name of the county in Iowa in which services were performed.

g. When the pay period covers services performed both in covered employment and in excluded work, show the hours and wages for covered employment under the Iowa employment security law, hereinafter referred to as the "Act," and also show hours and wages for excluded work.

h. The physical work site at which each employee worked during each pay period which includes the twelfth of each month. If an employee worked at more than one work site, the work site at which the majority of the work was performed should be the one of record.

22.1(3) Such payroll records may be preserved by the employer in microfilm form, provided the employer:

a. Keeps a microfilm viewer available, and

b. Is willing to transcribe any information that may be required by the department.

22.1(4) Maintenance of records by out-of-state employing units. Any employing unit having its principal place of business outside of Iowa shall maintain payroll records in this state with respect to wages paid to employees who perform some service in this state; provided, however, that an out-of-state employing unit may, with the approval of the department, maintain such payroll records outside the state upon its understanding that it will, when requested so to do, furnish the department with a true and correct copy of such payroll records. Failure to maintain said records in Iowa as required may result in estimated reports and payroll listings being made by the department. See 871—subrule 23.59(2).

This rule is intended to implement Iowa Code section 96.11(6)*"a."*

871—22.2(96) Reports. Each employing unit shall make such reports at such times as the department may require, and shall comply with the instructions printed upon any report form issued by the department pertaining to the preparation and return of such report.

This rule is intended to implement Iowa Code section 96.11(1).

871—22.3(96) Filing of Employer's Contribution and Payroll Report, 65-5300 and Employer's Payroll Continuation Sheet, 60-0103.

22.3(1) Each employer shall, by the due date, file a 65-5300, Employer's Contribution & Payroll Report, for each quarter listing wages paid with respect to all the employer's business maintained within this state computed in accordance with the Iowa Code and these rules.

22.3(2) Failure to receive report forms shall not relieve the employer from responsibility for filing required forms on or before the due date or to pay any contribution due.

22.3(3) A copy of each such report shall be preserved by each such employer for a period of at least five years from the end of the calendar year in which the report was due.

22.3(4) Employer to file report even when no payroll. Every qualified or subject employer is required to send in an Employer's Contribution and Payroll Report, Form 65-5300, each quarter. Even though an employer finds that for some particular quarter no contributions are due, or they have no employees during the period covered, a report must be filed with the department.

22.3(5) Combined reports, leased employees, and concurrently employed individuals.

a. Consolidated or combined reports of parent and subsidiary corporations or other employing units, whether or not the employing units are related, shall not be allowed.

b. Employees of parent and subsidiary corporations or other employing units, whether or not they are related, shall be reported on the quarterly reports of the employing unit for which the services are performed regardless of which employing unit actually issues the employees' paychecks.

c. Leased employees:

(1) Except as described in subparagraphs (2), (3), (4), and (5) below, individuals leased from an employee leasing company, by the client of the employee leasing company, shall be considered to be employed by the client and shall be reported on the quarterly reports of the client, at the contribution rate of the client, unless and until it is shown to the satisfaction of the department that the individuals are and will continue to be under the exclusive direction and control of the employee leasing company, both under a written contract and in fact.

In order for a contract to be considered evidence that individuals are the employees of the employee leasing company it shall:

1. Specify the service to be performed by the individuals, on behalf of the employee leasing company, for the client.

2. Specify the fee the client must pay for this service. The fee must be large enough to cover the actual cost of the individuals' wages and fringe benefits plus provide a reasonable profit on the service performed for the client.

3. Specify that the employee leasing company has the exclusive right to determine the number of individuals needed to provide the service for the client and to direct and control the individuals in the performance of the service.

4. Specify that the employee leasing company has the exclusive right to hire, fire, discipline, and reassign any of the individuals to another position or to another client without the consent of the client.

(2) If an individual is leased to fill a temporary need from a company whose business is primarily to provide workers to fill temporary needs, the individual shall be considered to be the employee of the leasing company as long as a written contract is in place.

(3) If an individual is a truck driver leased from a company that leases truck tractors with drivers to trucking companies, the individual shall be considered to be the employee of the leasing company unless and until it is shown to the satisfaction of the department that the trucking company has the exclusive right to hire, fire, discipline, reassign, and direct and control the services performed by the individual, both under a written contract and in fact.

(4) If an individual leased from an employee leasing company is a corporate officer of the client, the individual shall always be considered the employee of the client and not the employee of the leasing company.

(5) If an individual leased from an employee leasing company holds an exempt relationship, as defined in Iowa Code section 96.19(18)*"g"*(5), with the client, the individual shall not be considered to be an employee of either the client or the leasing company unless an election to cover the individual has been filed and approved in accordance with Iowa Code section 96.8(3)*"b."*

d. Concurrently employed individuals.

(1) Except as described in subparagraph (2) below, individuals who perform services concurrently for more than one employing unit, whether or not the employing units are related, shall be considered as working for each of the employing units and shall be reported on the quarterly reports of each of the employing units. Each of the employing units shall be required to pay contributions on the wages attributable to that employing unit up to the taxable wage base limit for each calendar year.

(2) An individual who concurrently performs services as a corporate officer for two or more related corporations and who is paid through a common paymaster that is one of the related corporations may be treated as working for only the common paymaster at the discretion of the related corporations.

22.3(6) Each Form 65-5300, Employer's Contribution & Payroll Report, shall include:

a. The social security number, name (last name first), and total wages paid to each employee during the calendar quarter. All corrections to previous reports must be submitted on Form 68-0061, Employer's Wage Adjustment Report. All employees' wages will be reported by the reporting unit under which the work was performed. See rules 871—23.3(96) through 871—23.6(96).

b. The sum of the total and taxable wages paid to all employees during the calendar quarter. If reported electronically, the sum of the total and taxable wages will be computed for the employer. The electronic system will compute the taxable wages for each employee. If the employer is claiming taxable wages reported to another state, the amount claimed and the state that the wages were reported to will be listed.

c. The amount of contribution due for the calendar quarter. If the report is filed electronically, the system will compute and enter the contribution due.

d. The amount of interest due, if any, for the calendar quarter. If the report is filed electronically, the system will compute and enter the interest due.

e. The amount of penalty due, if any, for the calendar quarter. If the report is filed electronically, the system will compute and enter any penalty due.

f. The total amount of contribution, interest and penalty due for the calendar quarter. If the report is filed electronically, the system will compute and enter the total amount due.

g. Rescinded IAB 5/5/10, effective 6/9/10.

h. The amount of net remittance due for the calendar quarter; however, if the amount of net remittance due is less than $1, the employer need not submit payment. If the report is filed electronically, the system will compute and enter the net remittance due.

i. The total number of employees listed on the report. If the report is filed electronically, the system will compute and enter the total number of employees on the report.

j. The amount of extraordinary pay which was paid to the employees during the calendar quarter for each reporting unit.

k. The total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter for each reporting unit.

l. The number of the county in which the reporting unit is located if only one business activity is conducted at only one worksite during the calendar quarter; however, if the same business activity is conducted at more than one worksite or if different business activities are conducted at one or more worksites, the employer shall also be required to complete and return the Form 65-5519, Multiple Worksite Report, which shall include for each worksite the total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter and the total wages paid during the calendar quarter. The system will compute and enter taxable wages if the report is filed electronically.

(1) The total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter for all worksites as reported on the Form 65-5519, Multiple Worksite Report, should equal the total number of employees reported for that month on the Form 65-5300, Employer's Contribution & Payroll Report.

(2) The total wages paid to all employees at all worksites as reported on the Form 65-5519, Multiple Worksite Report, should equal the total wages reported on the Form 65-5300, Employer's Contribution & Payroll Report.

(3) It could be possible for wages to be reported for a worksite without corresponding employment being reported in any of the months during the quarter because wages paid are reportable for the full 13-week period in the calendar quarter, while employment is reportable on the Form 65-5300, Employer's Contribution & Payroll Report, when such employment occurs during the pay periods which include the twelfth day of any month in the calendar quarter.

m. The reason (seasonal change, labor dispute, layoff, recall, worksite opening, or worksite closing) for the increase or decrease in total employment during the calendar quarter.

n. Rescinded IAB 3/5/03, effective 4/9/03.

o. The signature, written or electronic, of the owner, responsible officer, or authorized agent of the employer certifying that the information given is true and correct to the best of the signer's knowledge and belief, the date the report was submitted and the telephone number.

p. Such other schedules or reports as may be required, duly completed in all substantial respects on such forms and in accordance with such instructions as the department may provide or approve.

This rule is intended to implement Iowa Code sections 96.7, 96.11(6), 96.11(11) and 96.19(17).
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.4(96) Reporting of earnings data by secure file transfer.

22.4(1) The employer may submit an electronic file in lieu of Form 65-5300, Employer's Contribution & Payroll Report. Authorization for this reporting method will be given if the employer meets the specification requirements to be compatible with the department's computer capabilities. Such specifications will be furnished upon request.

22.4(2) The electronic file submitted will contain all of the employer information, wage information, and labor market information required when filing using the Form 65-5300, Employer's Contribution & Payroll Report. If this method of filing is selected, all wages must be filed using this method. The report will not be considered filed until all worksite reporting units have filed. All corrections to previous reports submitted to the department must be listed and submitted on Form 68-0061, Employer's Wage Adjustment Report.

22.4(3) The director shall annually designate the number of wage lines per report that will require the report be filed electronically.

This rule is intended to implement Iowa Code section 96.11(6)*"a."*
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.5(96) Filing of quarterly report forms by newly subject or covered employers. Any employing unit which becomes an employer subject to this chapter within any calendar quarter other than by a voluntary election of the employing unit shall file reports for each calendar quarter on Form 65-5300, Employer's Contribution and Payroll Report. Reports shall include all wages paid during the current quarter as well as separate quarterly reports for wages paid in prior quarters of the same calendar year. The first quarterly reports of that employer shall be due on the last day of the calendar month following the close of the calendar quarter in which the employing unit becomes subject to the Code and shall be considered delinquent if not submitted and paid by that date. Any employer filing a voluntary election for coverage must begin filing reports in the quarter the employer's election is effective.

This rule is intended to implement Iowa Code sections 96.7(1), 96.14(1), 96.14(2) and 96.8(3).

871—22.6(96) Employer changing status, address or name required to file report. Any employer who terminates business for any reason whatsoever, or transfers or sells all or a substantial part of the assets of the organization, trade or business to another, or changes the trade name of such business or

address thereof shall, within ten days after such termination, transfer, or change of name or address, give notice in writing to the department of that fact. The employer shall set forth in such notice the former name, address of the business, the new name, telephone number and address, the name of any new owner, and the employer's own name, telephone number and present address. Such notification shall be on Form 60-0111, Employer's Notice of Change, or on Form 65-5313, Employer's Delinquency Notice.

This rule is intended to implement Iowa Code sections 96.11 and 96.8(4).

871—22.7(96) Exempt employing units and exempt employment.

22.7(1) Any employing unit having workers performing services for it which it considers exempt from this Act shall file a Form 68-0192, Questionnaire for Determining Status of Workers, along with supporting exhibits and documents (i.e., contract, statements from employer and claimant) so that a decision can be made as to whether or not such service is in fact exempt from the provisions of this Act.

22.7(2) Any employing unit which has established its status as an organization exempt under this Act or that certain employment performed for it is not subject to contributions shall immediately notify the department of any changes in the character of its organization, the purposes and manner of its operation or the changed manner in which employment theretofore determined to be exempt by the department is performed.

22.7(3) Whenever an employing unit claims that any employment is not employment under this Act, the burden shall be on the employer to prove the exemption claimed.

This rule is intended to implement Iowa Code section 96.19(18)*"f."*

871—22.8(96) Subject employers.

22.8(1) Requesting determination of status. Whenever an employing unit is in doubt as to whether or not an individual is an employee, or is engaged in employment subject to the Act, the employing unit shall submit a statement of all relevant facts to the department for a determination as to the status under the Act of such individual or employment on Form 68-0192, Questionnaire for Determining Status of Workers, information for use in obtaining a ruling from the department as to whether or not a worker is an employee for the purposes of the Act.

22.8(2) Notification of status. The department shall maintain a separate account for each employer and shall notify the employer by mailing a Form 65-5308, Notice of Employer Status and Liability, to the last-known address. This notice will advise the employer of:

a. The effective subjectivity date.

b. The date of the determination (last day of quarter in which subjectivity occurred). See rule 22.5(96).

c. The assigned industry code.

d. The section of the law under which the employer was found liable.

e. The federal identification number (if available).

f. The workforce development unemployment insurance account number.

g. The contribution rate for that year and preceding four years, if applicable.

h. Whether the account was established new, reestablished or placed on an inactive status.

22.8(3) For the specific procedure and requirements for perfecting an appeal of an employer liability determination see rules 871—23.52(96) to 23.56(96).

This rule is intended to implement Iowa Code section 96.7(4).

871—22.9(96) Employing units required to file report to determine liability.

22.9(1) Each employing unit engaged in doing business in the state of Iowa January 1, 1936, or after, shall file a report to determine liability with the department on a form supplied by the department, Form 60-0126, Report to Determine Liability, setting forth the names and addresses of the owners of the business, or if a corporation, association, or joint stock company or limited liability company, the names and addresses of its officers or members. Each employing unit must show its principal place of business, the nature of its business, the number of individuals whom it customarily hires to perform services for it, the place or places where such services are performed, the time when such business was

begun, the number of weeks in the year for which it is customary to operate such business and such other information as may be required by such form.

22.9(2) Each employing unit which shall hereafter begin business in the state of Iowa in any manner whatsoever whether by succession to a business already being operated, by starting a new business, or otherwise, shall, within 30 days after beginning such business, inform the department of that fact, request the forms referred to in 22.9(1) and make and file the report required of all employing units by said rule.

This rule is intended to implement Iowa Code section 96.11(1).

871—22.10(96) Report of a Partnership on Change in Partners.

22.10(1) *Change in partnership.* In any case in which a partnership consisting of two or more partners adds to or deletes a partner or partners and is not required by the Internal Revenue Service to obtain a new federal identification number after such addition or deletion of partner or partners, the partnership shall notify the department of such change by filing a Form 68-0234, Report of a Partnership on Change in Partners, within ten days from the date the change occurred. The department will subsequently correct the partnership account to reflect this change.

22.10(2) *Reporting requirement.* If, after the change in partners, the partnership is required to obtain a new federal identification number by the Internal Revenue Service, or if there has been a change of ownership as described in Iowa Code section 96.19(18)*"b"* or a change of ownership as described in rule 871—23.28(96), then the old partnership shall notify the department by filing Form 60-0111, Employer's Notice of Change, within ten days from the date the change occurred. The new partnership shall notify the department by filing Form 60-0126, Report to Determine Liability, within ten days from the date the change occurred.

This rule is intended to implement Iowa Code section 96.11(6).

871—22.11(96) Employer account.

22.11(1) The department shall maintain one account for each employer (or single legal entity). An employer who has more than one establishment or business shall be considered to be one employing unit entitled to one account and a single experience rate. If an establishment or business owned by an employer is a separate legal entity in its own right (i.e., a subsidiary corporation), it will be considered to be a separate employer and must have an experience rate based on its own experience. When an already covered employer acquires another establishment or business, the employer will have a separate account number with a separate experience rate for the acquired business only if that business retains its character as a separate legal entity. If the acquired business is merged with that of the employer so that they become a single legal entity under the law, the successor is not entitled to separate rates for each establishment or business.

22.11(2) Each employer shall report all wages paid and pay all contributions into the unemployment account maintained by the department. The title of the employer's account shall be the name of the individual, partnership, corporation, association or other organization constituting the employing unit, and may contain the trade name used by the employing unit. Where the employing unit is a fiduciary agent or legal representative, the title of the account shall be the name of the fiduciary or legal representative and the official title.

22.11(3) Each employer's account shall be assigned a number and, unless the system of numbering accounts is changed, the number identifying an employer's account shall not be changed.

22.11(4) Establishment defined. As used in this rule, "establishment" means an economic unit, generally at a single physical location, where business is conducted, or where services or industrial operations are performed, or from which employees are dispatched.

This rule is intended to implement Iowa Code sections 96.7(2)*"a"*(1) and 96.19(17).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.12(96) Reporting units. Any employer having two or more separate establishments will file those establishments as separate reporting units. Additionally at the employer's discretion, the employer may establish reporting units to report according to function within the business. When filing a Form

65-5300, Employer's Contribution & Payroll Report, by paper, all reporting units will be listed on a separate page and will all be submitted together. When filing a Form 65-5300, Employer's Contribution & Payroll Report, by electronic means, the individual reporting units may be filed separately by the reporting units when authorized but the complete account report is not submitted until all reporting units are completed. Maintaining current status for the reporting units will be the employer's responsibility. If any reporting units are deleted or added, the department shall be notified within ten working days from the date of change.

This rule is intended to implement Iowa Code sections 96.7(2)*"a"* and 96.19(6).
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.13(96) Procedure to be followed by an employer wishing to have an active reporting unit coded for notice of claim for unemployment benefit mailing.

22.13(1) Any employing unit reporting under an assigned account and having one or more reporting units in the state of Iowa may request in writing or electronically the assignment of a reporting unit number which will be assigned for the specific purpose of mailing Form 65-5317, Notice of Claim Filing, to the reporting unit so that responsible personnel at that location can make a timely protest on Form 65-5317 if the employment separation was for a disqualifiable reason. Those accounts so wishing may request in writing that all unemployment insurance material other than Form 65-5317, Notice of Claim Filing, be sent to the home office or regional accounting office. All such requests must be from a responsible financial or operating officer of the firm and shall indicate:

a. Full trade name and address of each location to be coded.

b. The full employer name and address of the home office or financial office where all unemployment insurance material other than Form 65-5317 is to be sent.

22.13(2) It will be permissible to accept this information over the telephone by qualified personnel of the field audit section providing the employer makes known all of the above requested information and the person receiving this information notes the date it was received, the time it was received, who telephoned the information to the department, and the name and telephone number of a responsible party that can be contacted if further verification is needed with respect to the location coding procedure. Field audit section personnel receiving this classified information by telephone will accordingly note this and make it a matter of permanent record.

This rule is intended to implement Iowa Code section 96.6(2).
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.14(96) Notification by employer of employee's rights. Each employer shall post and maintain in places readily accessible to individuals in its employ printed notices or posters, Form 60-0160, informing employees of their potential rights to benefits under the employment security law and providing general instructions as to what the employees shall do and where the employees shall go to obtain these benefits. Copies of these printed notices or posters may be obtained from the department, upon request, without cost to the employer.

This rule is intended to implement Iowa Code section 96.11(2).

871—22.15(96) 940 certification.

22.15(1) Upon request, the department shall furnish to the Internal Revenue Service a certification of an employer's account for a particular year. Certification requests may be on an individual basis or may be part of a bulk yearly certification. Such certification will include the employer's state account number, yearly taxable payroll, contribution rate, contributions paid prior to January 31 of the next succeeding year, and the date and amount of contributions after January 31 of the next succeeding year.

22.15(2) In addition to the information certified in subrule 22.15(1), yearly certification shall include:

a. Employers who filed a federal unemployment tax return (Form 940) that did not file with the department.

b. Employers who filed returns with the department but not with the Internal Revenue Service except governmental employers and employers that department records indicate to be 501(c)(3) nonprofit organizations.

This rule is intended to implement Iowa Code sections 96.11(1) and 96.11(6)*"c"*(2).

871—22.16(96) Transmittal.

22.16(1) *Effect of postmark date.*

a. When the due date for filing reports and paying contributions falls on Saturday, Sunday or a legal holiday it is sufficient compliance with the law if reports and contributions are postmarked on or before midnight of the next succeeding business day following such Saturday, Sunday or legal holiday.

b. Contributions, if mailed, shall be deemed to have been paid on the date of mailing as indicated by the postmark on the cover thereof. If no postmark date on the cover, the date received by the department shall be deemed date of payment.

22.16(2) Reserved.

This rule is intended to implement Iowa Code sections 96.7(1) and 96.14(2).

871—22.17(96) Procedures of field auditors.

22.17(1) Field auditors are to provide a cost-effective method of promoting employers' understanding of employer rights and responsibilities under Iowa unemployment insurance laws.

22.17(2) The department, through duly appointed field auditors, may examine an employer's records at any time, subject to the limitations of 22.1(96), to determine compliance with Iowa Code chapter 96.

22.17(3) The department has enforcement authority. An employer, when requested to produce records by an auditor, must make the records available within and at a reasonable time to the auditor. If an employer does not comply with the auditor's request to produce records, a subpoena duces tecum may be served on the employer to appear before the auditor with the records in accordance with Iowa Code section 96.11, subsections 8 and 9.

22.17(4) The department, through duly appointed field auditors, may perform a systematic audit of an employer's records as authorized by Iowa Code section 96.11, subsection 7, and as mandated by the United States Department of Labor. In addition to the provisions of subrules 22.17(1) to 22.17(3), the following provisions apply to systematic audits:

a. The employer is to be given reasonable notice of the intent to audit, and a preaudit interview is to be conducted with the employer or a designated representative.

b. The records required, if maintained, may include individual pay records, Internal Revenue Service Forms W-2 and 1099, cash disbursement journal, check register, chart of accounts, general ledger, balance sheet, profit and loss statement, federal and state tax returns and other records to the extent they relate to possible hidden or misclassified wages.

c. To verify the existence of the business, the auditor may require a visit to the business premises or to see other evidence of legitimate business activity.

d. To verify the correct business entity is listed on department files, the auditor may examine various employer business licenses, legal documents or other tax returns.

e. To verify the reporting of all workers reportable to the department under Iowa Code chapter 96, questionable entries will be investigated and documented. Under rule 22.7(96) if the employer disagrees with the audit decision on coverage of a worker, the auditor may require the employer to complete Form 68-0192, Job Service Questionnaire For Determining Status of Workers. In any disputed case, the auditor is to be granted access to records as necessary to determine the remuneration paid for any given calendar quarter.

f. To verify proper employer posting to department reports, a detailed audit of check stubs, weekly time cards, or other maintained source documents will be made and documented for at least one worker for at least one quarter. The detailed audit may be more comprehensive at the discretion of the auditor or if discrepancies are found.

g. Employer records will be compared and reconciled to amounts reported to the department on contribution and payroll reports and audit findings documented.

h. Discrepancies will be resolved or explained, and report adjustments prepared as necessary.

i. The audit will cover four calendar quarters; however, if material errors are found, the audit may be expanded to cover prior or subsequent years subject to limitations of subrule 22.1(1). The auditor will review and correct similar errors in a minimum of a year prior to and after the audited year.

j. Additional amounts due will be calculated and collected, including applicable interest and penalties, or an explanation will be given. The employer may be required to submit a payment plan.

k. When the audit is completed, the audit will be discussed with the employer or a representative designated by the employer. The employer will be furnished copies of any wage adjustments, supplemental reports or delinquent reports prepared by the auditor. An audit report with all worksheets, adjustments and reports will be retained by Iowa workforce development.

22.17(5) There are several other reasons department representatives may make employer contacts and demands under authority of this rule. Any of these activities may be expanded into a systematic compliance audit as described in subrule 22.17(4) upon approval of the duly authorized representative of the department.

a. An auditor may request to examine business records to determine the date employment began and the date the employing unit became subject to Iowa Code chapter 96.

(1) To determine if an employing unit is to be a covered employer and if an individual, or class of individuals, are employees whose remuneration would be subject to contributions, the auditor will examine employment contracts and related documents.

(2) If it is determined that the employing unit is to be a covered employer, the auditor will examine legal documents such as leases, purchase contracts, partnership agreements, articles of incorporation, limited liability operating agreements and stock records to determine ownership of the business, to establish responsibility for filing reports and paying contributions, and to assist in the determination of the unemployment insurance tax rate.

(3) If liability is determined, the payroll/remuneration records may be examined to establish the correct amount of covered wages and the period to which they belong. Reports will be completed and the correct amount of contribution, penalty and interest due will be computed and collection action will be initiated.

b. When an unemployment insurance claim is filed, an auditor may request to examine the records of an employer to establish the claimant's rights to benefits under Iowa Code chapter 96. Form 68-0192, Job Insurance Questionnaire For Determining Status of Workers, and supporting documents may be required in contested cases. If the department determines that the claimant is an employee, the records will be examined to determine the correct amount of wages paid to the claimant and the period to which the wages apply.

c. When an employer fails or refuses to file a report, the auditor may examine the records to determine the correct amount of wages that should be reported, prepare the report, compute and collect contributions, penalty, and interest due. Should records not be made available, the auditor may estimate the wages paid and amounts due pursuant to 871—subrule 23.59(2).

d. When an employer is delinquent in paying contributions due, the auditor may examine records including cash accounts, accounts receivable, real and personal property accounts, accounts payable, notes payable, installment contracts and mortgages payable to determine the employer's equity in the assets on which a lien may be filed and judgment obtained.

22.17(6) When a temporary writ of injunction has been filed by the department, pursuant to Iowa Code section 96.16, against an employer because of the employer's failure or refusal to file a required report or to pay assessed contributions, penalty, and interest, a field auditor shall have the right to inspect the enjoined business premises during reasonable hours and interview any interested parties having knowledge of or being involved with the enjoined employer to ensure that such enjoined employer and all of the employer's agents, servants, employees, and assigns are observing the conditions of the temporary writ of injunction.

This rule is intended to implement Iowa Code sections 96.7(1), 96.7(3), 96.8(1), 96.11(1), 96.11(6)*"a,"* 96.11(7), 96.14, 96.16 and 96.20(3).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—22.18(96) Agents and other practitioners or firms representing employers in unemployment insurance matters.

22.18(1) An agent, tax practitioner, accounting firm, attorney or any other firm or individual that represents or intervenes on behalf of an employer in any unemployment insurance matter shall have on file with the department:

a. A power of attorney, or

b. A letter of authorization from the employer, or

c. An electronic designation of authority from the employer.

22.18(2) The foregoing documents shall contain the following information:

a. Employer's full legal name, address and account number.

b. Employer doing business as (DBA) or trade name if any.

c. Legal name, address, telephone number and federal employer identification number (FEIN) of the agent or firm representing the employer.

d. Employer's E-mail address.

e. Address of the designated agent.

f. Roles that the agent or firm is authorized to perform for the employer.

g. Signature of the employer.

22.18(3) Rescinded IAB 3/5/03, effective 4/9/03.

This rule is intended to implement Iowa Code section 96.11(7).

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CHAPTER 23
EMPLOYER'S CONTRIBUTION AND CHARGES

[Prior to 9/24/86, Employment Security[370]]
[Prior to 3/12/97, Job Service Division [345] Ch 3]

871—23.1(96) Definitions.

23.1(1) *Accounts.*

a. Benefit payment account. An account maintained in the unemployment compensation fund in which are recorded (1) amounts transferred from the unemployment trust fund in the United States treasury, and receipts from other sources, and (2) amounts of benefits paid.

b. Employer rating account. An account of an employer which is maintained by the department for the purpose of reporting wages and recording contributions or reimbursements for that employer.

c. Clearing account. An account maintained in the unemployment compensation fund in which are recorded all amounts payable under Iowa Code chapter 96, including those to be transferred to (1) the unemployment trust fund, (2) the special employment security contingency fund, (3) the administrative contribution surcharge fund, and (4) the temporary emergency surcharge fund. Employer refunds are issued from this account.

d. Balancing account. An account set up to receive benefit charges that by law are not chargeable to any employer. The purpose of the balancing account is to enable the department to properly account for all benefits paid out.

23.1(2) *Average annual taxable payroll.* The average of the total amount of taxable wages paid by an employer for insured work during the five periods (three or two periods for governmental contributory employers) of four consecutive calendar quarters immediately preceding the computation date.

23.1(3) *Calendar quarter.* The period of three consecutive calendar months ending on March 31, June 30, September 30, or December 31 of each year.

23.1(4) *Computation date.* The date as of which employers' experience with respect to unemployment or unemployment risk is measured for the purpose of determining contribution rates.

23.1(5) *Employer's contribution and payroll report.* An employer's quarterly report of the wages paid to individual workers, the total and taxable wages paid and the amount of contributions due to a state unemployment insurance fund.

23.1(6) *Contributions.* Payments required by a state employment security law to be made to the state unemployment fund by reason of insured work but does not include reimbursement payments of nonprofit organizations or governmental entities in lieu of contributions.

23.1(7) *Contributor rate.* The percent constituting the rate at which the employer's payroll is taxed.

23.1(8) *Employer.* An employer subject to the employment security law of Iowa who is liable for contributions and subject to the experience rating provisions of the law or is liable for reimbursement payments in lieu of contributions. (See Iowa Code section 96.19(16).)

23.1(9) *Experience.* An employer's record with respect to contributions paid, benefits charged, and taxable wages reported.

23.1(10) *Experience rating.* A method for determining the contribution rates of individual employers on the basis of the factors specified in the state employment security law for measuring employers' experience with respect to unemployment or unemployment risk.

23.1(11) Reserved.

23.1(12) Rescinded IAB 5/14/03, effective 6/18/03.

23.1(13) Reserved.

23.1(14) *Federal unemployment tax.* The tax imposed by the Federal Unemployment Tax Act on employers with respect to having individuals in their employ.

23.1(15) *Federal Unemployment Tax Act.* Subchapter C of Chapter 23 of the Internal Revenue Code which relates to the federal unemployment tax.

23.1(16) *Federal unemployment tax return.* A report by an employer to the Internal Revenue Service of the amount of federal unemployment tax due and payable with respect to wage payments to workers during the calendar year.

23.1(17) Rescinded IAB 5/14/03, effective 6/18/03.

23.1(18) *Funds.*

a. Administrative contribution surcharge fund. A special fund in the state treasury, established by state law, as a repository for an employer surcharge levied to meet the operational cost of certain state workforce development offices. Referred to in subrule 23.40(2).

b. Administrative funds. Funds made available from federal, state, local and other sources to meet the cost of state workforce development administration.

c. Contingency fund. An amount of money appropriated by Congress to meet certain unpredictable increases in costs of administration by the state workforce development divisions arising from increases in workload or other specified causes.

d. Employment security administration fund. A special fund in the state treasury, established by state law, in which are deposited moneys granted by the United States Department of Labor, manpower administration and moneys from other sources, for the purpose of paying the cost of administering the state workforce development program.

e. Special employment security contingency fund. A special fund in the state treasury, established by state law, for moneys received from employers in payment of interest and penalties on delinquent contributions and reports.

f. Temporary emergency surcharge fund. A special fund in the state treasury, established by state law, for use in the event an employer surcharge is levied to pay interest on a federal government loan to the unemployment compensation fund. Referred to in subrule 23.40(3).

g. Title V funds. Funds appropriated by Congress to pay unemployment benefits under Title V of the United States Code to federal civilian and military employees.

h. Unemployment compensation fund. A special fund established under an employment security law for the receipt and management of contributions and the payment of unemployment insurance benefits. Included in this fund are moneys in the benefit payment account, clearing account, and unemployment trust fund account.

i. Unemployment trust fund. A fund established in the treasury of the United States which contains all moneys deposited with the treasury by the state employment security agencies to the credit of their unemployment fund accounts and by the railroad retirement board to the credit of the railroad unemployment insurance account.

23.1(19) *Indian tribe.* Indian tribe has the same meaning given to the term by Section 4(e) of the federal Indian Self-Determination and Education Assistance Act, and shall include any subdivision, subsidiary, or business enterprise wholly owned by such an Indian tribe.

23.1(20) Reserved.

23.1(21) Rescinded IAB 5/14/03, effective 6/18/03.

23.1(22) and **23.1(23)** Reserved.

23.1(24) *Liability determination.* A determination as to whether an employing unit is a subject employer and whether services performed for it constitute employment as defined under the employment security law.

23.1(25) *Liability report.* A report required of all employing units in a state, which gives the information on which the state employment security agency bases its determination as to whether the employing unit is liable under the state employment security law.

23.1(26) *Subject employer.* An employing unit which is subject to the contribution provisions of a state employment security law.

23.1(27) *Tax.* (See "Contributions.")

23.1(28) *Unemployment compensation fund.* The unemployment compensation fund established by this chapter to which all contributions or payments in lieu of contributions are required to be deposited and from which all benefits provided under Iowa Code chapter 96 shall be paid. (See "Funds.")

23.1(29) Rescinded IAB 5/14/03, effective 6/18/03.

23.1(30) *Quarterly Wage report.* A report by an employer of the wages of individual workers.

23.1(31) *Quarterly Wage listing.* A report listing workers and their wages by social security number.

This rule is intended to implement Iowa Code sections 96.7(2)*"c"*(3), 96.7(7)*"b,"* 96.11(1) and 96.19(1).

871—23.2(96) Definition of wages for employment during a calendar quarter.

23.2(1) Unless the context otherwise requires, terms used in rules, forms, and other official pronouncements issued by the department shall have the following meaning:

23.2(2) Wages paid. Wages for employment during a calendar quarter consist of wages paid during the calendar quarter. Wages earned but not paid during the calendar quarter shall be considered as wages for employment in the quarter paid. The Employer's Contribution and Payroll Report, Form 65-5300, shall be used as prima facie evidence of when the wages were paid. If the wages are not listed on the 65-5300, they shall be considered as paid:

a. On the date appearing on the check.

b. On the date appearing on the notice of direct deposit.

c. On the date the employee received the cash payment.

d. On the date the employee received any other type of payment in lieu of cash.

23.2(3) Wages payable means wages earned and unpaid. (See section 96.19(41).)

23.2(4) Wages is the name by which the remuneration for employment is designated and the basis on which the remuneration is paid is immaterial. It may be paid in cash or in a medium other than cash, on the basis of piece work or percentage of profits, commission, or it may be paid on an hourly, daily, weekly, monthly or annual basis. Remuneration paid in goods or services shall be computed on the basis of the fair value of the goods or services at the time of payment.

23.2(5) When the cash value for board or lodging, or both, furnished a worker is agreed upon in a contract of hire, the amount so agreed upon, if more than the rates specially determined by the department or the rates prescribed herein, shall be deemed the cash value of the board and lodging.

23.2(6) Cash value of room and board.

a. If board, rent, housing, lodging, meals, or similar advantage is extended in any medium other than cash as partial or entire remuneration for service constituting employment as defined in Iowa Code section 96.19(18), the reasonable cash value of same shall be deemed wages subject to contribution.

b. Where the cash value for such board, rent, housing, lodging, meals, or similar advantage is agreed upon in any contract of hire, the amount so agreed upon shall be deemed the value of such board, rent, housing, lodging, meals or similar advantage. Check stubs, pay envelopes, contracts, and the like, furnished to employees setting forth such cash value, are acceptable evidence as to the amount of the cash value agreed upon in any contract of hire except as provided in paragraphs *"d"* and *"e"* of this subrule.

c. In the absence of an agreement in a contract of hire, the rate for board, rent, housing, lodging, meals, or similar advantage, furnished in addition to money wages or wholly comprising the wages of an employed individual, shall be deemed to have not less than the following cash value except as provided in paragraph *"d"* of this subrule.

Full board and room per week	$272.00
Meals (without lodging) per week	92.00
Meals (without lodging) per day	18.40
Lodging (without meals) per week	180.00
Lodging (without meals) per day	36.00
Individual meals:	
Breakfast	4.00
Lunch	4.80
Dinner	9.60
A meal not identifiable as either breakfast, lunch or dinner	4.00

d. The department or its authorized representative may, after affording reasonable opportunity at a hearing for the submission of relevant information in writing or in person, determine the reasonable cash value of such board, rent, housing, lodging, meals, or similar advantage in particular instances or

group of instances, if it is determined that the values fixed in or arrived at in accordance with paragraph *"c"* of this subrule, or in the contract of hire do not properly reflect the reasonable cash value of such remuneration.

e. If the department determines that the reasonable cash value is other than prescribed in a contract of hire or in paragraph *"c"* of this subrule, the employer's payroll and contribution reports to the department shall thereafter show the value of such remuneration as determined by the department.

f. Notwithstanding the provisions of this paragraph, the cash value of meals which are provided by and for the convenience of the employer on the business premises of the employer shall not be deemed as insured wages under chapter 96 of the Iowa Employment Security Law. Lodging furnished by the employer, for the convenience and on the business premises of the employer, shall not be considered wages if the employee is required to accept the lodging as a condition of employment.

This rule is intended to implement Iowa Code section 96.19(41).

871—23.3(96) Wages.

23.3(1) *"Wages"* means all remuneration for personal services, including commissions and bonuses and the cash value of all remuneration in any medium other than cash. Wages also means wages in lieu of notice, separation allowance, severance pay, or dismissal pay. The reasonable cash value of remuneration in any medium other than cash shall be estimated and determined in accordance with rule 23.2(96).

23.3(2) The term "wages" shall not include:

a. Subsistence payments. The amount of payment made by an employer to its employee, which is in addition to the employee's regular wages and is paid for the sole purpose of compensating the employee for expenses inherent in the performance of services by the employee away from the regular base of operation of the employer and employee, commonly referred to as subsistence pay.

b. Travel and other ordinary and necessary expenses. Amounts paid specifically for travel or other ordinary and necessary expenses incurred or reasonably expected to be incurred in the employer's business are not wages. Travel and other reimbursed expenses must be identified either by making a separate payment or by specifically indicating the separate amounts if both wages and expense allowances are combined in a single payment.

c. Employer's payments to persons performing military services. Cash payments, or the cash value of other remuneration, made voluntarily and without contractual obligation to, or in behalf of, an individual for periods during which such individual is in active service or training as a member of the national guard, or the military or naval forces of the United States, including the organized reserves.

d. Sick pay.

(1) "Wages" shall not include any amounts paid as sick pay if the payments are made by or on behalf of an employer under a plan or system. The plan or system must provide sick pay for the employees of the employer or a class or classes of the employer's employees. The plan may include dependents.

(2) In the absence of a plan or system any amounts paid by or on behalf of an employer on account of sickness shall not be included after the expiration of six calendar months following the last calendar month in which the employee worked for such employer.

e. Supplemental unemployment benefit plan (SUB). The term "wages" shall not include the amount of any payment by an employing unit for or on behalf of an individual in its employ, under a plan or system established by such employing unit, with approval of the department. Such plan or system must make provision for payment to a trust fund or similar account on behalf of individuals performing services for it. The account must be used to pay supplemental unemployment benefits to such employing unit's employees over and above any sum to which such employees might be entitled under the provisions of the state employment security law. Such payments to employees are not remuneration for the purposes of reducing or preventing payment of unemployment benefits. Such plan shall contain the following features:

(1) The employer pays into a separately established trust fund or similar account an amount per hour (or amount equivalent) worked by the employees covered by the agreement until the maximum amount called for has been reached. The plan specifically provides for the supplementation of unemployment benefits under the written terms of an agreement, contract, trust arrangement, or other instrument.

(2) These payments made by the employer into the trust fund or similar account are not subject to recovery by the employer before the satisfaction of all liabilities to employees covered by the plan.

(3) The trust fund or similar account is to be used to pay supplemental unemployment benefits to employees over and above any sum to which they might be entitled under the provisions of a state employment security law.

(4) That the agreement shall provide that such employee is not entitled to receive any payment from the trust fund or similar account unless the employee is also concurrently eligible for benefits under a state employment security law.

(5) The plan requires that benefits are to be determined according to objective standards. Thus a plan may provide similarly situated employees with benefits which differ in kind and amount, but may not permit such benefits to be determined solely at the discretion of the administrator of the fund.

(6) That the employee has no vested right in any of the moneys paid into the trust fund or similar account except as the employee may qualify for benefits under the terms of the agreement.

(7) That any payment made to or on behalf of an employee be from and to a trust fund or similar account described in Section 401(a) of the United States Internal Revenue Code title 26 of 1970 which is exempt from tax under Section 501(a) of said Code.

(8) The employer shall seek approval of its plan by petitioning that its plan be designated as a supplemental unemployment benefit (SUB) plan in the manner provided for petitioning for a declaratory ruling. The employer should include a written copy of its plan in the petition for declaratory ruling. The department will respond in the manner provided for declaratory rulings.

f. Officers of corporation. The term "employment" shall not include wages paid to an officer of corporation if such officer is a majority stockholder:

(1) Unless such services are subject to a tax to be paid under any federal law imposing a tax against which credit may be taken for contributions required to be paid into a state unemployment fund; or

(2) If such services are required to be covered under this chapter of the Code as a condition to receiving a full tax credit against the tax imposed by the Federal Unemployment Tax Act (FUTA) (26 U.S.C. 3301-3309).

g. Remuneration paid by state or political subdivision. The term "employment" shall not include wages paid by this state or any of its political subdivisions or by an Indian tribe to:

(1) An elected official,

(2) A member of a legislative body,

(3) A member of the judiciary of a state or political subdivision,

(4) A member of the state national guard or air national guard,

(5) An employee serving on a temporary duty basis for fire, storm, snow, earthquake, flood, or similar emergency, or

(6) A person serving in a nontenured policymaking capacity or advisory capacity pursuant to state law which ordinarily does not require duties of more than eight hours per week.

See rule 871—23.71(96) for further definition of exemptions (1) through (6).

h. Sole proprietorship or partnership drawing accounts. The term "wages" shall not include any of the following:

(1) Any amount of personal compensation withdrawn by a bona fide sole proprietor from the business or profession.

(2) Any amount of personal compensation withdrawn by a bona fide partner or partners from their partnership entity.

(3) Remuneration for services which are paid by a limited partnership to a limited partner is reportable. If a limited partner performs the duties of a general partner, remuneration is considered to be exempt.

i. Payments into 401K and other deferred compensation plans. Payments made by an employer to a deferred compensation plan, established to provide for an employee's retirement, are not wages subject to contributions unless the payments were deducted from the employee's pay through a salary reduction agreement. In circumstances where both the employer and the employee contribute to the plan,

the employer's share is not wages unless the employee would receive a cash payment if the employee chose not to participate in the plan.

j. Remuneration paid to members of limited liability companies based on membership interest. The term "wages" shall not include remuneration paid to a member of a limited liability company based on a membership interest in the company provided that the remuneration based on membership interest is allocated among members, or classes of members, in proportion to their respective investments in the company. The term "wages" shall not include any remuneration for services performed in lieu of a contribution of cash or property to acquire a membership interest in the limited liability company. See Iowa Code sections 96.19(18a)(9) and 96.19(41e). If the amount of remuneration attributable to membership interest or the purchase of a membership interest and the amount attributable to services performed cannot be determined, the entire amount of remuneration shall be considered to be based on the services performed.

k. Inmates of correctional institutions. The term "employment" shall not include wages paid for services performed by an inmate of a correctional institution. Persons in work release programs are considered inmates and their wages are not reportable. Remuneration paid to residents of halfway houses is reportable.

23.3(3) The term "wages" shall include:

a. Small business corporation remuneration. Remuneration paid to officers of "subchapter S" corporations for services performed in Iowa shall be deemed to be wages. Any corporate dividends must be approved and recorded in the corporate minutes prior to payment of such dividends. Remuneration to shareholders shall not be deemed to be dividends if such remuneration is paid regularly, either weekly or monthly, and is not in proportion to such shareholder's amount of stock, or in proportion to such shareholder's investment in the corporation. Corporate dividends are not considered wages. Ordinary income distributions as reported on IRS Form K-1 will not be considered to be wages provided that distributions are made proportionate to stock ownership or shareholder's investment, and provided that corporate officers performing services for the corporation have received appropriate remuneration for services performed as defined by the Internal Revenue Service and the remuneration is reported as wages. See subrule 23.3(2)*"f"* for possible exclusion of wages paid to corporate officers who are majority stockholders.

b. Wages of employees hired with equipment. Where an employee is hired with equipment, except where it is ordinary in custom and usage in the trade or business for employees to furnish such equipment at their own expense, the fair value of the remuneration for the employee's services, if specified in the contract of hire, shall be considered wages. If the contract of hire does not specify the employee's wages, or the value of the wages agreed upon under the contract of hire is not a fair value, the department shall determine the employee's wages, taking into consideration the prevailing wages for similar work under comparable conditions, and the wages thus determined shall apply as wages and be so reported by the employer.

c. Union members. Members of a union, subject to the direction and control of the union and acting on behalf of the union, are considered employees of the union with respect to the services performed. Payments made to them by the union as reimbursement for time lost from their regular employment are considered wages.

d. Cafeteria plans. A cafeteria plan is a set of benefit options offered by the employer to employees or to a class of employees. A particular benefit in a cafeteria plan will be considered to be "wages" subject to contributions (tax) for Iowa unemployment insurance purposes if the employee has the option of receiving a cash payment in lieu of the benefit. If the employee does not have the option of receiving a cash payment, the benefit will still be considered "wages" subject to contributions unless the benefit is specifically excluded from the definition of "wages" in Iowa Code subsection 96.19(41).

e. Personal use of company vehicle. The cash value of personal use of a company automobile or other vehicle is "wages" subject to contributions (tax) for Iowa unemployment insurance purposes and shall be reported to the department as wages paid in the quarter in which the personal use occurred.

This rule is intended to implement Iowa Code sections 96.5(5)*"a,"* 96.19(6)*"a"*(1) and (6), and 96.19(41).

871—23.4(96) Wages—back pay. A payment in the form of or in lieu of back pay to an individual (exclusive of legal fees and other litigation expenses) shall be reported by the employer as total and taxable wages paid to the individual in the quarter in which the employer actually made the payment in the form of or in lieu of back pay. A payment for back pay shall be taxable and recoverable if it meets the definition of wages contained in rule 23.3(96). Punitive or liquidated damages for other than lost wages, and job search expenses, are not taxable, recoverable or deductible as a back pay award.

23.4(1) Where the back pay wages, award or a judgment is paid as remuneration for employment by an employer into an account for an individual, the wages, award or judgment shall be considered as wages paid in the quarter in which the employer actually pays the wages, award or judgment to an account for the individual.

23.4(2) If an individual receives benefits for a period of unemployment and subsequently receives a payment in the form of or in lieu of back pay for the same period, and if the benefits are recovered by the department under an agreement between the employer and the individual allowing the employer to deduct and remit to the unemployment compensation fund the amount of benefits received by the individual from the payment in the form of or in lieu of back pay, the employer shall be required to report this amount to the department as total and taxable wages paid to the individual in the calendar quarter in which the amount is actually paid.

This rule is intended to implement Iowa Code sections 96.7(3) and 96.8(5).

871—23.5(96) Gratuities and tips.

23.5(1) The following criteria shall be applicable in determining whether tips are wages under the contributions provision of the Act: Tips received by an individual from a person or persons other than the individual's employer, and not accounted for to the employer, are not wages unless required by subrule 23.5(2). If the employee makes an accounting to the employer listing the tips received, these tips must be reported to the department as total and taxable wages. Where the customer writes the amount of the tip on a bill and the employer pays the employee the amount so shown and charges it to the customer's account, such amounts are wages. Where the employer adds a certain percent to the customer's bill for disbursement to the employees, the sums so disbursed are wages.

23.5(2) Tips are considered reportable and taxable as wages when taken into account by the employer in determining the employee's compensation under the federal wage and hour law, or when paid by the customer as a service charge set by the employer, or when pooled and distributed to the employees by the employer. The employer shall keep sufficient detailed records so that it can be ascertained, if necessary, by audit or other authorized inspection which compensation is reportable as taxable tips and which compensation is reportable as compensation other than tips. For reporting purposes to the department, the tips and other reportable and taxable compensation may be submitted in aggregate on Form 65-5300, Employer's Contribution and Payroll Report.

23.5(3) An accounting as used in this rule means the reporting of tips as gratuities by an employee to the employer for the purpose of deducting social security taxes or withholding taxes with the employer reporting the same on Form 941, Employer's Quarterly Federal Tax Return.

871—23.6(96) Taxable wages.

23.6(1) *Definition.*

The term *"taxable wages"* means the higher of the federal taxable wage base for the Federal Unemployment Tax Act (FUTA) or 66 2/3 percent of the statewide average weekly wage paid to employees in insured employment, multiplied by 52 and rounded to the next highest multiple of $100 based upon the computation made during the previous calendar year to determine the maximum weekly benefit amounts for unemployment insurance benefits.

23.6(2) *Applicability and successorship.*

a. If an individual has more than one employer, each employer must pay contributions (tax) on the employee's wages up to the taxable wage base.

b. The employer shall not deduct any part of the contributions (tax) due on taxable wages from an employee's pay.

c. Taxable wages paid in another state by the same employer during the same calendar year prior to an employee being transferred to Iowa may be used in computing the employee's reportable taxable wages in Iowa.

d. A successor employer may use the taxable wages paid and reported by the predecessor employer to determine the successor employer's taxable wages if the successor employer received a transfer of experience from the predecessor employer.

e. A successor employer which received a transfer of experience may, at the successor employer's option, use the taxable wages reported by the predecessor to compute the taxable wages for the balance of the calendar year or may compute the taxable wages as if the employees acquired from the predecessor were new employees.

This rule is intended to implement Iowa Code section 96.19(37).

871—23.7(96) New employer contribution rates.

23.7(1) A contributory employer means all employers other than employers which have elected, or are required by law, to reimburse the department for benefits paid in lieu of paying contributions. An employer which has earned a "zero" rate is still considered to be a contributory employer.

23.7(2) A nonconstruction contributory employer, which has not yet qualified for an experience rate, shall pay contributions at the rate specified in the twelfth benefit ratio rank but not less than 1 percent until the end of the calendar year in which the employer's account has been chargeable with benefits for 12 consecutive calendar quarters immediately preceding the computation date.

23.7(3) A construction contributory employer, which has not yet qualified for an experience rate, shall pay contributions at the rate specified in the twenty-first benefit ratio rank until the end of the calendar year in which the employer's account has been chargeable with benefits for 12 consecutive calendar quarters.

23.7(4) Once an employer has qualified for an experience rating, the rate will be computed in accordance with the formula given in Iowa Code section 96.7. Rates will vary from 0 percent to 9 percent depending on how each employer's experience compares to the experience of all other employers.

23.7(5) For the purposes of this rule, an administrative contribution surcharge and a temporary emergency surcharge may be added to an employer's contribution rate.

23.7(6) For the purposes of this rule, the first quarter in which an employer's account will be considered chargeable with benefits will be the third quarter of the employer's liability unless the employer paid and reported no wages during the first two quarters of liability. In that case, the employer will not be considered chargeable with benefits until the first quarter in which the employer pays and reports wages. Once an employer's account has been chargeable with benefits it will be considered chargeable for rate computation purposes until it is terminated.

23.7(7) For the purposes of this rule, any single employer which has two or more establishments or businesses engaged in different industrial classification activities, with one or more establishments or businesses engaged in construction activity, as defined in rule 23.82(96), shall be assigned the contribution rate applicable to construction if 50 percent or more of the combined business activity is derived from the establishments or businesses engaged in construction activities.

This rule is intended to implement Iowa Code section 96.7.

871—23.8(96) Due date of quarterly reports and contributions.

23.8(1) *Due date.*

a. Contributions shall become due and be payable quarterly on the last day of the month following the calendar quarter for which the contributions have accrued. If the department finds that the collection of any contributions from an employer will be jeopardized by delay, the department may declare the contributions due and payable as of the date of the finding.

b. If any due date prescribed in this rule falls on a Saturday or Sunday, or a legal holiday, the due date shall be the next following business day. Quarterly reports, contributions, and payments in lieu

of contributions, if mailed, shall be considered as received on the date shown on the postmark of the envelope in which they are received by the department.

23.8(2) *Regular due date.* Each covered employer subject to Iowa Code section 96.7 shall file with the department quarterly reports on or before the due date, and any employer failing to file a quarterly report when due shall be delinquent.

23.8(3) *Due date for new employer.* The first contribution payment of any employer who becomes newly liable for contributions in any year shall become due and payable on the last day of the month following that quarter wherein occurred the twentieth calendar week, during the calendar year within which a total of one or more workers were employed on any one day, or the last day of the month following that calendar quarter in which a total of $1,500 in wages was paid. The first payment of such an employer becoming liable in the course of a calendar year shall include contributions with respect to all wages paid for employment from the first day of the calendar year.

a. The first contribution payment of any agricultural employer who becomes newly liable for contributions in any year will become due and payable on the last day of the month following that quarter wherein occurred the twentieth calendar week, during the calendar year within which a total of ten or more workers were employed on any one day, or the last day of the month following that calendar quarter in which a total of $20,000 in wages was paid. The first payment of such an employer becoming liable in the course of a calendar year shall include contributions with respect to all wages paid for employment from the first day of the calendar year.

b. The first contribution payment of any domestic employer who becomes newly liable for contributions in any year will become due and payable on the last day of the month following that quarter wherein the liability was established, or the last day of the month following that calendar quarter in which a total of $1,000 in wages was paid. The first payment of such an employer becoming liable in the course of a calendar year shall include contributions with respect to all wages paid for employment from the first day of the calendar year.

23.8(4) *Due date for elective coverage.* The first contribution payment of any employing unit which elects with the written approval of such election by the department, to become an employer, or to have nonsubject services performed for it deemed employment, shall become due and payable on the last day of the month next following the close of the calendar quarter in which the conditions of becoming an employer by election are satisfied, and shall include contributions with respect to all wages paid for employment occurring on and after the date stated in such approval (as of which such employing unit becomes an employer), up to and including the calendar quarter in which the conditions of becoming an employer by election are satisfied.

23.8(5) *Due date for newly liable employer.* The first contribution payment of an employer who becomes newly liable for contributions in any year in any other manner shall become due and be payable on the last day of the month next following the quarter wherein such individual or employing unit became an employer. The first payment of such an employer shall include contributions with respect to all wages paid for employment for such individual or employing unit since the first day of the calendar year.

23.8(6) *Delinquent date and penalty and interest.*

a. A quarterly report or contribution payment or payment in lieu of contributions which is not received on or before the due date is delinquent. An employer who fails to file on or before the due date a contribution and wage report shall pay to the department for each such delinquent report, subject to waiver for good cause shown, a penalty as provided in Iowa Code section 96.14(2). No penalty shall apply to delinquent reports when the employer proves to the satisfaction of the department that no wages were paid.

b. An employer who has not paid contributions or payments in lieu of contributions on or before the due date shall pay interest on the whole or part thereof remaining unpaid at the rate of 1 percent per month, or 1/30 of 1 percent for each day or fraction thereof, from and after the due date until payment is received by the department unless good cause is shown why such interest shall be waived.

23.8(7) *Due date upon demand.* If the department finds that the collection of any contribution or payment in lieu of contributions will be jeopardized by delaying the collection thereof until the date

otherwise described, upon written demand by the department, such contribution or payment in lieu of contribution shall become immediately payable, and shall become delinquent.

23.8(8) *Extension of time.* Upon written request filed with the department before the due date of any contribution report, the department may, for good cause shown, grant an extension in writing of the time for filing of the report and the payment of the contributions, but no extension shall exceed 30 days and no extension shall postpone payment beyond the last day for filing tax returns under the Federal Unemployment Tax Act. If an employer who has been granted an extension fails to pay the contribution on or before the termination of the period of such extension, interest shall be payable from the original due date as if no extension had been granted.

This rule is intended to implement Iowa Code section 96.7(1).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.9(96) Delinquency notice. Within 20 days from the delinquent date for filing Form 65-5300, Employer's Quarterly Contribution & Payroll Report, a Delinquency Notice, Form 65-5313, will be sent to all employers from whom no report has been received. Such notice shall state the employer's name, account number, experience rate, and the quarter for which the report needs to be made. The notice will be sent to the employer's last-known address or place of business. If the employer has sold or dissolved the business, the employer shall fill out the information section on Form 65-5313, showing the date of the last wages paid and the date of last employment. If the business was sold or transferred, the employer shall show the name and address of the successor and the employer's future mailing address. Such notice shall then be returned to the department for a change of status determination.

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.10(96) Payments in lieu of contributions.

23.10(1) An employer who has qualified for reimbursement payments or has had an election to become a reimbursable employer approved shall pay to the department an amount equal to the amount of regular or extended benefits paid, including benefits which are based on wage credits transferred from another employer. If extended benefits are in effect, employers shall reimburse one-half of the extended benefits paid; except governmental employers and Indian tribes shall reimburse all extended benefits paid.

23.10(2) At the end of each calendar quarter, the department shall bill each reimbursable employer on Form 65-5324, Notice of Reimbursable Benefit Charges. This statement shall be sent to the employer within 30 days of the quarter for which the benefits are charged and shall set out the social security number, name and amount of benefits charged to the employer for each such claimant together with the amount of any previous charges remaining unpaid and interest to the end of the quarter for which the statement is rendered. Payment of each quarter's charges shall be due within 30 days of the date the statement is sent. If the employer fails to reimburse the department within the period prescribed by these rules the department may attempt collection of the amount due including any of the following methods:

a. Issuance of Notice of Assessment and Lien, Form 68-0043.

b. Issuance of Notice of Jeopardy Assessment, Form 68-0138.

c. Any other actions as prescribed by the law or these rules including collection by distress warrant.

Interest on delinquent reimbursable benefits shall be charged at the rate of 1 percent per month or one-thirtieth of 1 percent per day from the date payment was due until the date of payment.

This rule is intended to implement Iowa Code section 96.7(8).

871—23.11(96) Identification of workers covered by the Iowa employment security law.

23.11(1) Each employer shall ascertain the federal social security number of each worker employed by such employer in employment subject to the Iowa employment security law.

23.11(2) The employer shall report the worker's federal social security number in making any report required by the department of workforce development with respect to the worker.

23.11(3) If a worker failed to report to the employer such employee's correct federal social security number or fails to show the employer a receipt issued by an office of the social security board acknowledging that the worker has filed an application for an account number, the employer

shall inform the worker that Regulation 106 of the Internal Revenue Service, United States Treasury Department, under the Federal Insurance Contribution Act provides that:

a. Each worker shall report to every employer for whom the worker is engaged in employment a federal social security number with the worker's name exactly as shown on the social security card issued to the worker by the social security board.

b. Each worker who has not secured an account number shall file an application for a federal social security account number on Form SS-5 of the Treasury Department, Internal Revenue Service. The application shall be filed on or before the seventh day after the date on which the worker first performs employment for wages, except that the application shall be filed on or before the date the worker leaves employment if such date precedes such seventh day.

c. If, within 14 days after the date on which the worker first performs employment for wages for the employer, or on the day on which the worker leaves the employ of the employer, whichever is the earlier, the worker does not have a federal social security account number, and has not shown the employer a receipt issued to the worker by an office of the social security board acknowledging that the worker has filed an application for an account number, the worker shall furnish the employer an application on Form SS-5, completely filled in and signed by the worker. If a copy of Form SS-5 is not available, the worker shall furnish the employer a written statement, signed by the worker, of the date of the statement, the worker's full name, present address, date and place of birth, father's full name, mother's full name before marriage, worker's sex, and a statement as to whether the worker had previously filed an application on Form SS-5 and, if so, the date and place of such filing. Furnishing the employer with an executed Form SS-5, or statement in lieu thereof, does not relieve the worker of the obligation to make an application on Form SS-5 as required in paragraph *"b"* of this subrule.

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.12 Reserved.

871—23.13(96) Employer elections to cover multistate workers.

23.13(1) *Arrangement.* The following rule shall govern the workforce development department in its administrative cooperation with other states subscribing to the interstate reciprocal coverage arrangement, hereinafter referred to as the arrangement.

23.13(2) *Definitions.* As used in this rule, unless the context clearly indicates otherwise:

a. "Jurisdiction" means any state of the United States, the District of Columbia, Puerto Rico, or, with respect to the federal government, the coverage of any federal unemployment compensation law.

b. "Participating jurisdiction" means a jurisdiction whose administrative agency has subscribed to the arrangement and whose adherence thereto has not terminated.

c. "Agency" means any officer, board, department, division, commission or other authority charged with the administration of the unemployment compensation law of a participating jurisdiction.

d. "Interested jurisdiction" means any participating jurisdiction to which an election submitted under this rule is sent for its approval; and interested agency means the agency of such jurisdiction.

e. "Services customarily performed by an individual in more than one jurisdiction" means services performed in more than one jurisdiction during a reasonable period, if the nature of the service gives reasonable assurance that they will continue to be performed in more than one jurisdiction or if such services are required or expected to be performed in more than one jurisdiction under the election.

f. "Total wages paid in covered employment," as it appears in Iowa Code section 96.7(2) for computing the benefit cost ratio, means total wages paid in covered employment, subject to contributions, as provided in Iowa Code section 96.7, and does not include wages paid by reimbursing employers whose payments to the unemployment fund, in lieu of contributions, are made in accordance with Iowa Code section 96.7.

23.13(3) *Submission and approval of coverage elections under the interstate reciprocal coverage arrangement.*

a. Any employing unit may file an election, on Form 68-0599, to cover under the law of a single participating jurisdiction all of the services performed for the employing unit by any individual who

customarily works for the employing unit in more than one participating jurisdiction. Such an election may be filed, with respect to an individual, with any participating jurisdiction in which:

(1) Any part of the individual's services are performed;

(2) The individual resides; or

(3) The employing unit maintains a place of business to which the individual's services bear a reasonable relation.

b. The agency of the elected jurisdiction (thus selected and determined) shall initially approve or disapprove the election. If such agency approves the election, it shall forward a copy thereof to the agency of each other participating jurisdiction specified thereon, under whose unemployment compensation law the individual or individuals in question might, in the absence of such election, be covered. Each such interested agency shall approve or disapprove the election, as promptly as practicable, and shall notify the agency of the elected jurisdiction accordingly. In case its law so requires, any such interested agency may, before taking such action, require from the electing employing unit satisfactory evidence that the affected employees have been notified of, and have acquiesced in the election.

c. If the agency of the elected jurisdiction, or the agency of any interested jurisdiction, disapproves the election, the disapproving agency shall notify the elected jurisdiction and the electing employing unit of its action and of its reasons therefor.

d. Such an election shall take effect as to the elected jurisdiction only if approved by its agency and by one or more interested agencies. An election thus approved shall take effect, as to any interested agency, only if it is approved by such agency.

e. In case any such election is approved only in part, or is disapproved by some of such agencies, the electing employing unit may withdraw its election within ten days after being notified of such action.

23.13(4) *Effective period of election.*

a. Commencement. An election duly approved under this rule shall become effective at the beginning of the calendar quarter in which the election was submitted, unless the election, as approved, specifies the beginning of a different calendar quarter. If the electing unit requests an earlier effective date than the beginning of the calendar quarter in which the election is submitted, such earlier date may be approved solely as to those interested jurisdictions in which the employer had no liability to pay contributions for the earlier period in question.

b. Termination.

(1) The application of an election to any individual under this rule shall terminate, if the agency of the elected jurisdiction finds that the nature of the services customarily performed by the individual for the electing unit has changed, so that they are no longer customarily performed in more than one particular jurisdiction. Such termination shall be effective as of the close of the calendar quarter in which notice of such findings is mailed to all parties affected.

(2) Except as provided in subparagraph (1) of this paragraph, each election approved hereunder shall remain in effect through the close of the calendar year in which it is submitted, and thereafter until the close of the calendar quarter in which the electing unit gives written notice of its termination to all affected agencies.

(3) Whenever an election under this rule ceases to apply to any individual, under subparagraph (1) or (2) of this paragraph the electing unit shall notify the affected individual accordingly.

23.13(5) *Reports and notices by the electing unit.*

a. The electing unit shall promptly notify each individual affected by its approved election on Form 68-0601 supplied by the elected jurisdiction, and shall furnish the elected agency a copy of such notice.

b. Whenever an individual covered by an election under this rule is separated from employment, the electing unit shall again notify the individual forthwith, as to the jurisdiction under whose unemployment compensation law the individual's services have been covered. If at the time of termination the individual is not located in the elected jurisdiction, the electing unit shall notify the individual as to the procedure for filing interstate benefit claims.

c. The electing unit shall immediately report to the elected jurisdiction any change which occurs in the conditions of employment pertinent to its election, such as cases where an individual's services

for the employer cease to be customarily performed in more than one participating jurisdiction or where a change in the work assigned to an individual requires such individual to perform services in a new participating jurisdiction.

871—23.14(96) Elective coverage of excluded services.

23.14(1) An employing unit having services performed for it which are not subject to the compulsory coverage provisions of the Act may file an application Form 68-0598, Voluntary Election, for voluntary election to become an employer under the law or to extend its coverage to individuals performing services which do not constitute employment as defined in the law.

a. In no case shall an elective coverage agreement under Iowa Code section 96.8(3) be approved unless and until it has been established that the employing unit making application for elective coverage is normally and continuously engaged in a regular trade, business or occupation.

b. An application for elective coverage shall be disapproved if the department finds that the employing unit at the time of making the application was insolvent or expected to discontinue business for any reason within one year from the date the application is filed, or that the employing unit is not normally and continuously engaged in a regular trade, business or occupation.

c. The department may, on its own motion, request a written statement as to why an employing unit wishes to file an election to become a subject employer as provided for in Iowa Code section 96.8(3)*"a"* and may request evidence of financial stability.

d. Any written election for a period prior to the date of filing shall become binding upon approval by the department, and notification of the approval shall be forwarded to the employer. If for any reason the department does not approve such voluntary election, the employing unit shall be notified of the reasons why such approval was withheld.

e. The date of filing of a voluntary election shall be deemed to be the date on which the written election, signed by a legally authorized individual, is received by the department.

f. Effect of election approval. Each approval of an election shall state the date as of which the approval is effective. The first contribution payment of any employing unit which elects to become a covered employer shall become due and shall be paid on or before the due date of the reporting period during which the conditions of becoming a covered employer by election are satisfied, and shall include employer contributions with respect to all wages paid on and after the date stated in such approval (as of which such employing unit becomes a covered employer), up to and including the last pay period in the reporting period in which the conditions of becoming a covered employer by election are satisfied.

23.14(2) Reserved.

871—23.15 and **23.16** Reserved.

871—23.17(96) Group accounts.

23.17(1) Reimbursable employers who desire to form a group account or reimbursable employers who wish to be added to an existing group account shall apply on Form 68-0534, Application for a Group Account.

a. New group accounts. The application shall list each proposed member and must be signed by each proposed member and shall appoint one member as the agent for the group for all dealings with the department.

b. Adding a member or members to an already existing group. The application shall list all members of the group including the new member(s) and shall be signed by all members of the group including the new member(s). The application shall set out one member as agent for the group, or an authorized agent of the group, with respect to all dealings with the workforce development department.

23.17(2) A government entity shall not be allowed to form a group with a nonprofit organization(s).

23.17(3) No application for a group account shall be approved if any member of the group is delinquent in the payment of contributions, interest or penalty, or in the filing of reports, or in the payment of reimbursable benefits.

23.17(4) If the application is denied by the department, a notice stating the reasons for denial will be sent to the agent for the group. A new application may be submitted by the group at any time.

23.17(5) If the application is approved by the department, a notice will be sent to the agent for the group. Such approval shall be effective with the first day of the quarter in which the application is received.

23.17(6) Such group account shall continue for a minimum period of one year from the first day of the quarter in which the application for a group account was received and no member may leave the group during such year except that withdrawal shall be allowed where the member's liability has terminated under Iowa Code section 96.8(2) or 96.8(4).

a. If a new member(s) is added to the group during the first year of the group's existence, the group shall continue for one year from the first day of the quarter in which the application to add the member is received and no member may leave the group during such year except where the member's liability has terminated under Iowa Code section 96.8(2) or 96.8(4).

b. If a new member(s) is added to the group after the group has been in existence for one year, only the new member(s) shall be obligated to remain with the group for an additional one-year period from the first day of the quarter in which such member joined the group.

23.17(7) After the group has been in existence for one year, unless provided for differently in 23.17(6)*"a"* or 23.17(6)*"b,"* any member may withdraw by providing the agent for the group and the department with notice of the withdrawal in writing. Such withdrawal shall become effective with the first day of the quarter following the quarter in which notice is received by the department. For the withdrawal to be effective with the first day of the quarter immediately following the first year of the group's existence, notice of withdrawal must be filed during the last three months of the first year of the group's existence.

23.17(8) Rescinded IAB 5/14/03, effective 6/18/03.

23.17(9) Should a government group or any group member default with respect to any payments due the department, the amount of such delinquency shall be deducted from any further moneys due to the members of the group by the state as provided in Iowa Code section 96.14(2).

23.17(10) Each member of a group shall be jointly and severably liable for any defaults by any members of the group with respect to unpaid reimbursable benefit charges and any interest and penalty. All charges to the members of a group shall be in accordance with the provisions of Iowa Code section 96.7(13).

23.17(11) Upon the formation of a group, all benefits paid after the effective date of the group based upon wages paid by any member(s) of the group shall be charged to the group regardless of when the wages upon which such benefits were earned except those benefits based upon wages paid when the member(s) was a nonprofit contributory employer. Benefits based on wages paid when a member(s) was a government contributory employer that are paid after the effective date of the group will be charged to the group.

23.17(12) Upon the occasion of a member withdrawing from a group and the member continues to be a liable employer, such member shall be liable for the payment of all benefits paid after the date of withdrawal and attributable to employment with such member regardless of when the wages upon which the benefits are based were earned.

23.17(13) Liability for benefits upon termination of a group or withdrawal of a defaulting or no longer liable member.

a. Notwithstanding subrules 23.17(1) to 23.17(12), when a group is terminated upon the application of all members or under subrule 23.17(7) where there are only two members, liability for any reimbursable benefits which the department concludes are not collectible from a defaulting ex-member(s) of the group and said benefits are based upon wages paid prior to or while the group was in existence shall lie with each of the former members of the group jointly and severably.

b. Notwithstanding subrule 23.17(12) when an ex-member of a group is in default at the time of withdrawal from the group or withdraws under subrule 23.17(7) and it is determined that the benefits are not collectible from such member, the group has remained in existence, and the benefits so paid are

based upon wages paid prior to or while the ex-member was a member of the group, the group shall be held liable for the payment of such benefits.

23.17(14) Agent's responsibilities.

a. The agent for a group shall be responsible, on behalf of the group members, for all the duties of an employer as set out in the Iowa Code and these rules. Specifically such agent shall be responsible for the pro-rata apportioning of benefit charges to each member of the group as set out in Iowa Code section 96.7(10) or be based on an experience rating system approved by the department and shall accept all legal services and notices on behalf of all members of the group.

b. All correspondence on behalf of the group shall be between the agent for the group and the department.

c. Each member of a group may submit quarterly wage information and labor market information for the member's reporting unit electronically or each member of a group shall submit a quarterly payroll report to the group's agent who shall combine such reports into one report for all reporting units on Form 65-5300, Employer's Contribution & Payroll Report, and shall submit such combined report to the department on or before the delinquent date for such quarter.

d. Submittal of the quarterly report electronically by worksite reporting unit will eliminate the requirement to submit the multiple worksite report.

e. Should an agent member withdraw from a group, or resign as agent, it shall immediately advise the department of its intent in writing. Such notice must be made at least 90 days prior to the date of withdrawal. The department shall notify the remaining members of the group of the withdrawal and shall request that the group elect a new agent. Such election must be held and the department notified of the result within 30 days of the notice of the withdrawal from the department. Failure to notify the department within 30 days of the new agent shall result in the termination of the group by the department.

23.17(15) Transfers and successorships.

a. If a member of a group sells or otherwise transfers its business to a nonmember and the acquiring employer has made or, at the time of acquisition is eligible to and makes an election to make payments in lieu of contributions, the successor shall assume the position of the predecessor in the group as of the date of acquisition.

b. If a member of a group sells or otherwise transfers a substantial portion of its business to a nonmember and the predecessor is a nonprofit organization and the successor is a governmental entity, the successor shall not acquire membership in the group.

c. If a member of a group sells or otherwise transfers a substantial portion of its business to a nonmember and the predecessor is a government entity and the successor is a nonprofit organization, the successor shall not acquire membership in the group.

d. If a member of a group sells or otherwise transfers a substantial portion of its business to an organization or other entity not eligible to make an election to make payments in lieu of contributions, the successor shall not acquire membership in the group.

e. A member of a group may become a successor to any other organization and remain in the group so long as the member remains a nonprofit organization or governmental entity.

f. Successors which are not permitted to enter a group under 23.17(15)*"b"* to 23.17(15)*"d"* shall be held liable for benefits which are based upon wages paid by the predecessor the same as provided in subrule 23.17(12) for members withdrawing from a group.

This rule is intended to implement Iowa Code section 96.7(10).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.18(96) Nature of relationship between employer-employee.

23.18(1) *Commission sales persons and insurance solicitors.* Commission sales persons generally are considered employees subject to the law regardless of the method of their remuneration unless they are independent contractors.

23.18(2) *Directors and officers of a corporation.* Directors who receive a reasonable fee for attending meetings and perform no other services are not employees of the corporation. Officers

of associations and corporations are included as employees if they perform services. Officers of a corporation who perform services for the corporation are employees.

23.18(3) *Members of family.*

a. Services performed by an individual in the employ of a son, daughter, or spouse, and services performed by a child under the age of 18 in the employ of a father or mother are exempt from the provisions of this Act.

b. Services performed by a foster parent in the employ of a foster child, by a stepparent in the employ of a stepchild, and by a child under the age of 18 years in the employ of a stepparent or foster parents are exempt from the provisions of this Act.

c. Services performed by a son or daughter over the age of 18 as an approved provider for consumer-directed care in the employ of a father or mother who is an approved consumer of a home- and community-based waiver services program are exempt from the provisions of Iowa Code chapter 96.

23.18(4) *Aliens.* This Act makes no distinction between citizens and lawful aliens. Lawful aliens in nonexempt employment are counted in determining whether the employer is subject to the Act and are covered by the contribution and benefit provision.

23.18(5) *Aged and minor employees.* Contributions are payable upon services rendered by an employee regardless of the age of the employee.

23.18(6) *Family employment.* Family employment includes parents, wife or husband and minor children under the age of 18 years working for an individual proprietor. This exclusion does not apply when the employing unit is a partnership unless an exempt relationship is held to each member of the partnership. This exclusion does not apply to corporations or to limited liability companies.

23.18(7) *Partners.* Bona fide partners are not considered employees even though they receive salaries.

23.18(8) *Apprentices-clerks.* This law makes no exceptions for persons serving a clerkship or other form of apprenticeship.

23.18(9) *Members of a limited liability company.* Members of a limited liability company that perform services other than for the purpose of acquiring membership in the limited liability company are employees.

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.19(96) Employer-employee and independent contractor relationship.

23.19(1) The relationship of employer and employee exists when the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. An employee is subject to the will and control of the employer not only as to what shall be done but how it shall be done. It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so. The right to discharge or terminate a relationship is also an important factor indicating that the person possessing that right is an employer. Where such discharge or termination will constitute a breach of contract and the discharging person may be liable for damages, the circumstances indicate a relationship of independent contractor. Other factors characteristic of an employer, but not necessarily present in every case, are the furnishing of tools, equipment, material and a place to work to the individual who performs the services. In general, if an individual is subject to the control or direction of another merely as to the result to be accomplished by the work and not as to the means and methods for accomplishing the result, that individual is an independent contractor. An individual performing services as an independent contractor is not as to such services an employee under the usual common law rules. Individuals such as physicians, lawyers, dentists, veterinarians, construction contractors, public stenographers, and auctioneers, engaged in the pursuit of an independent trade, occupation, business or profession, in which they offer services to the public, are independent contractors and not employees. Professional employees who perform services for another individual or legal entity are covered employees.

23.19(2) The nature of the contract undertaken by one for the performance of a certain type, kind, or piece of work at a fixed price is a factor to be considered in determining the status of an

independent contractor. In general, employees perform the work continuously and primarily their labor is purchased, whereas the independent contractor undertakes the performance of a specific job. Independent contractors follow a distinct trade, occupation, business, or profession in which they offer their services to the public to be performed without the control of those seeking the benefit of their training or experience.

23.19(3) Independent contractors can make a profit or loss. They are more likely to have unreimbursed expenses than employees and to have fixed, ongoing costs regardless of whether work is currently being performed. Independent contractors often have significant investment in real or personal property that they use in performing services for someone else.

23.19(4) Employees are usually paid a fixed wage computed on a weekly or hourly basis while an independent contractor is usually paid one sum for the entire work, whether it be paid in the form of a lump sum or installments. The employer-employee relationship may exist regardless of the form, measurement, designation or manner of remuneration.

23.19(5) The right to employ assistants with the exclusive right to supervise their activity and completely delegate the work is an indication of an independent contractor relationship.

23.19(6) Services performed by an individual for remuneration are presumed to be employment unless and until it is shown to the satisfaction of the department that the individual is in fact an independent contractor. Whether the relationship of employer and employee exists under the usual common law rules will be determined upon an examination of the particular facts of each case.

23.19(7) If the relationship of employer and employee exists, the designation or description of the relationship by the parties as anything other than that of employer and employee is immaterial. Thus, if such relationship exists, it is of no consequence that the employee is designated as a partner, coadventurer, agent, independent contractor, or the like.

23.19(8) All classes or grades of employees are included within the relationship of employer and employee. For example, superintendents, managers and other supervisory personnel are employees.

871—23.20(96) Employment—student and spouse of student. Wages earned by a student who performs services in the employ of a school, college or university at which the student is enrolled and is regularly attending classes (either on a full-time or part-time basis) are not covered wages for claim or benefit purposes.

Wages earned by an individual who is a full-time employee for a school, college or university whose academic pursuit is incidental to the full-time employment are covered wages.

Wages earned by the spouse of such a student in employment with the educational institution attended by the student are not covered wages for benefit purposes if the employee-spouse is told prior to commencing the employment that the work is part of a program to provide financial assistance to the student and is not covered by unemployment insurance.

This rule is intended to implement Iowa Code section 96.19(18)*"g"*(6).

871—23.21(96) Excluded employment—student. Wages earned by a student who is enrolled at a nonprofit or public educational institution under a program taken for credit at such institution that combines academic instruction with work experience are normally excluded from the definition of employment. Provided, however, that no work performed by such individual in excess of the hours called for in the contract between the school and the employer or performed in a period of time during which the institution is on a regularly scheduled vacation and for which such student receives no academic credit shall be excluded from said definition.

This rule is intended to implement Iowa Code section 96.19(18)*"g"*(6).

871—23.22(96) Employees of contractors and subcontractors.

23.22(1) If one employer contracts with another employing unit for any work which is part of the first employer's usual business, the first employer is liable for any contributions based on wages paid by the second employing unit in connection with the work providing the second employing unit is not liable to pay contributions.

23.22(2) Employees of the second contractor are counted as employees of the first contractor while performing services on the contract for the first contractor.

871—23.23(96) Liability of affiliated employing units. An employing unit not qualifying as a covered employer under any other section of this law shall be a liable employer if together with one or more employing units owned or controlled by the same interest, the combined employment or quarterly gross wages (counting together the number of workers or the combined gross quarterly wages of each enterprise) would total one or more workers in a portion of a day in each of 20 different weeks or have a combined gross quarterly payroll which equals or exceeds $1,500 in a calendar quarter.

871—23.24(96) Localization of employment—employees covered—exemption.

23.24(1) When workers perform services in more than one state, the department will review each case individually and make a determination whether or not wages are reportable to Iowa based on the following guidelines in sequence:

a. Services performed in a state are considered localized in that state regardless of where the employer is located. The wages are reportable to the state where the services are performed.

b. When a worker performs services in more than one state and the length of service in any one state is equal to or greater than a reporting period, the worker is reportable to that state. A reporting period is defined as a full calendar quarter. This rule does not apply if work is performed in multiple states during the reporting period.

c. Where services are performed among two or more states in a reporting period, the base of operations is considered. The base of operations is the point from which the workers start and finish their work on a regular basis and that is the state to which the wages are reportable. In this type of case, the department has the right to waive Iowa coverage to another jurisdiction (state of the base of operations) as long as the employee is properly covered by the other state.

d. When workers perform services in more than one state and there is no base of operations in any one state, the state from which the worker is immediately directed and controlled is the state to which the wages are reportable provided that some services are performed by the worker in that state.

e. If the services of the workers are not localized in a state, the base of operations is not involved or the place where services are directed and controlled is not applicable, then the wages are reportable to the state in which the worker resides provided some services are performed in that state.

23.24(2) Reserved.

This rule is intended to implement Iowa Code section 96.19(18)*"b."*

871—23.25(96) Domestic service.

23.25(1) Services of a household nature performed by an individual in or about the private home of the person by whom the individual is employed or performed in or about the club rooms or house of a local college club or local chapter of a college fraternity or sorority by which the individual is employed are included within the term "domestic service."

23.25(2) A private home is the fixed place of abode or residence of an individual or family, including the house and the lands on which the house stands.

23.25(3) Services of a general household nature are those ordinarily and customarily performed as an integral part of the upkeep operation and maintenance of a dwelling, residence or private home. In general, covered services of a household nature in or about a private home include services rendered by workers such as cleaning people, cooks, maids, housekeepers, caretakers, yard workers and similar domestic workers. In addition, services performed by babysitters, nannies, health aides and similar workers for members of the household are covered.

23.25(4) The services enumerated above are not covered under the term "domestic service" if performed in or about rooming or lodging houses, boarding houses, clubs (except local college clubs), hotels, offices or other commercial enterprises.

23.25(5) The term "domestic service" does not include the service of a skilled mechanic engaged in recognized independent craft not habitually rendered as a part of ordinary household duties. In situations

where it may be necessary to determine whether or not an employer-employee relationship exists between the householder and the household worker, the guidelines as set forth in 871—23.19(96) will be applied.

23.25(6) Rescinded IAB 5/14/03, effective 6/18/03.

23.25(7) Services of a household nature performed in or about the club rooms or house of a local college club, or in or about the club rooms or house of a local chapter of a college fraternity or sorority, by a student who is enrolled and regularly attending classes at a school, college, or university are excepted from employment. For the purpose of this exception, the statutory tests are the type of services performed by the employee, the character of the place where the services are performed, and the status of the employee as a student enrolled and regularly attending classes at a school, college, or university where the term "school, college, or university" is taken in its commonly or generally accepted sense.

23.25(8) In general, services of a household nature in or about the club rooms or house of a local college club or local chapter of a college fraternity or sorority include but are not limited to services rendered by cooks, janitors, laundry persons, furnace persons, handy persons, gardeners and housekeepers.

23.25(9) A local college club or local chapter of a college fraternity or sorority does not include an alumni club or chapter. If the club rooms or house of a local college club or local chapter of a college fraternity or sorority is used primarily for the purpose of supplying board or lodging to students or the public as a business enterprise, the services performed there are not covered under the term "domestic service."

23.25(10) Rescinded IAB 5/14/03, effective 6/18/03.

23.25(11) Where an individual is employed by a domestic service or home health care organization to perform domestic services in a private home, the individual is an employee of the service firm, not the householder.

This rule is intended to implement Iowa Code sections 96.19(13) and 96.19(16)*"m."*

871—23.26(96) Definition of a farm—agricultural labor.

23.26(1) "Farm" as used in section 96.19(6)*"g"*(3) and as used in these rules means one or more plots of land not necessarily contiguous, including structures and buildings, used either primarily for raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry and furbearing animals and wildlife or both such uses, if the activities conducted on the plot or plots of land have as their purpose the accomplishment of an objective which is agricultural in nature.

23.26(2) The definition of farm given in subrule 23.26(1) includes, but is not limited to, nurseries, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities. A parcel of real property or a portion of a parcel of real property which is used primarily for the raising of nursery stock from seeds, cuttings or transplanted stock is a farm. If any parcel of real property or a portion of a parcel of real property is used both for the raising of nursery stock and for display of nursery stock or allied products for sale, the parcel or portion is not a farm if the raising is not the primary operation. A parcel of real property or a portion of a parcel of real property which is used primarily to display nursery stock for sale, or to display an allied product for sale, or both, is not a farm. Allied product, as used in this rule, includes but is not limited to, garden supplies, lawn supplies, tools, equipment, fertilizers, sprays, insecticides or pottery.

23.26(3) If other than incidental sales of an allied product are made in connection with a nursery, the operations in connection with the sales area are commercial operations as distinguished from ordinary farm operations and services performed with respect to the sales areas are not agricultural labor.

23.26(4) A plot of land used primarily for the raising of Christmas trees is a farm.

23.26(5) The following shall be used to determine whether or not services are defined as agricultural labor.

a. Services performed by an individual on a farm, in the employ of any owner, tenant or operator, in connection with the operation constitutes agricultural labor if:

(1) The services are on the farm on which the materials in their raw or natural state were produced, and

(2) Processing, packing, packaging, transportation, or marketing is carried on as an incident to ordinary farming operation.

b. If the service is performed as an incident to industrial, manufacturing or commercial operation it does not constitute agricultural labor. (Example: Services performed for an insurance company in repair and construction of farm buildings do not constitute agricultural labor.)

23.26(6) Services performed on nonfarm property while in the employ of one who is not the owner, tenant or operator of the farm to which the operation relates or any service rendered in connection with the maintenance and repair of equipment, used in operation on the farm, as well as related collection, clerical and bookkeeping services, are not agricultural labor.

23.26(7) Services performed in the handling or processing of any agricultural or horticultural commodity are included as agricultural employment if performed in the employ of the owner, tenant, or other farm operator, only if the commodity is in a nonmanufactured state and only if the operator produced more than half of the commodity with respect to which the service was performed.

23.26(8) Aerial seeding, fertilizing, spraying, dusting, custom planting, cultivating or combining of farm acres while in the employ of any agricultural enterprise is agricultural labor. These include mixing or loading into the airplane the spraying or dusting material, as well as the measuring of the swaths and the marking and flagging of the fields, and is considered agricultural as long as it is performed on a farm. If any of these services are performed on property other than a farm, they are not agricultural labor and are covered by the other provisions of the Iowa employment security law.

23.26(9) If the employer does not own or operate the farm which is being sprayed or dusted, any service related to employees in connection with maintenance and repair of the aircraft, trucks, or other equipment used in those operations, as well as related collection, clerical and bookkeeping services, are not agricultural labor and are not exempt under the Iowa employment security law.

23.26(10) Services performed on a farm in the employ of any person in connection with hatching poultry are agricultural labor. A plot of land together with the structures and buildings located off the farm, devoted to the hatching of poultry, is not considered to be a farm. Any service, under any contract of hire, performed off the farm in connection with the hatching of poultry shall not be considered agricultural labor.

23.26(11) Executive, supervisory, administrative, clerical, stenographic, and office work are not agricultural labor although they may be rendered on a farm and in relation to a farm.

23.26(12) Services performed on a farm incidental to the overall commercial activities which are not incidental to ordinary farming operation or directly related to the farming operation are not agricultural labor.

23.26(13) Services performed in connection with the processing of agricultural commodities performed on a farm, for a farm operation, are not agricultural labor unless one-half or more of the commodities processed are produced by the farm operator.

23.26(14) Services performed in agricultural employment as defined in Iowa Code section 96.19(18)*"g"*(3) or rule 23.26(96) by an agricultural employee one-half or more of any calendar month shall be considered agricultural employment the whole of that calendar month.

871—23.27(96) Exempt employment in the employ of a church, association of churches or an organization which is operated primarily for religious purposes.

23.27(1) The word *"church"* is used in its limited sense and is synonymous with an individual house of worship maintained by a particular congregation. Any service by an individual for a church, convention or association of churches is excluded from coverage. However, the exclusion does not apply to service performed for an organization which may be religious in orientation unless it is operated primarily for religious purposes and is operated, supervised, controlled or principally supported by a church (or a convention or association of churches). Thus, the service of the janitor of a church is excluded, but the service of a janitor for a separately incorporated college, although it may be church related, is covered.

23.27(2) Service for a college devoted primarily to the preparation of students for the ministry is exempt, as is service for a novitiate or a house of study, training candidates to become members of

religious orders. On the other hand, a church-related (separately incorporated) charitable organization (such as an orphanage or a home for the aged) is not considered, under this Act, to be operated primarily for religious purposes.

23.27(3) The exclusion of service performed by ministers in the exercise of their ministry and by members of a religious order in performing the duties required by such order applies only when such service is performed for nonprofit organizations ordinarily required to be covered by the Iowa employment security law.

23.27(4) A minister is ordained, commissioned, or licensed, if such minister has been vested with ministerial status in accordance with the procedure followed by the particular church denomination. However, such minister does not have to be connected with a congregation. Ministerial authority continues until revoked by the church.

23.27(5) The term *"exercise of the ministry"* includes: the conduct of religious worship and the ministration of sacerdotal functions; service performed in the control, conduct, and maintenance of a religious organization under the authority of a religious body constituting a church or church denomination, or an organization operated as an integral agency of such a religious organization or of a church or church denomination; service performed for any organization under an assignment or designation by a church (not including cases in which a church merely helps a minister by recommending such minister for a position involving nonministerial services for an organization not connected with the church); and missionary service or administrative work in the employ of a missionary organization. Control, conduct, and maintenance of an organization do not include services such as operating an elevator, or being a janitor, but refers to services performed in the directing, management, or promotion of the activities of the organization.

23.27(6) Accordingly, service of a clergyman (clergywoman) as a chaplain in an orphanage or in an old-age home is excluded since such service is in the exercise of a ministry as is the service of members of a teaching or nursing order who are engaged in teaching or nursing. In the case of a member of a religious order, the criterion is whether the order requires the performance of such service.

23.27(7) School coverage.

a. Schools that are not separately incorporated and are affiliated with a church are exempt from insured employment because their employees are in the direct employ of a church or convention or association of churches.

b. Schools that are separately incorporated and are affiliated with a church are exempt from insured employment if such schools are operated primarily for religious purposes.

c. Schools that are not affiliated with a church are covered employers with covered employment.

"Affiliated" as used in this rule means operated, supervised, controlled, or principally supported by a church or convention or association of churches. A school which is operated primarily for religious purposes must have as its chief and principal purpose for operation a religious orientation. The school must have as its purpose of first or highest rank of importance the religious indoctrination of its students.

This rule is intended to implement Iowa Code section 96.19(18)*"a"*(6)(a) and (c).

871—23.28(96) Successor.

23.28(1) Definition of *"successor employer"* as used in Iowa Code section 96.7 and these rules means an employing unit which:

a. Acquired the organization, trade or business, or substantially all the assets of an employing unit that was subject to the provisions of chapter 96 prior to the acquisition, regardless of whether the acquirer was an employing unit prior to the acquisition. The acquiring employer must continue to operate the enterprise or business.

b. An employing unit that acquired a severable portion of the business of an employer who is subject to chapter 96 providing:

(1) The portion of the business or enterprise acquired would have in itself met the requirements of section 96.19(16)*"a."*

(2) An application is made for a transfer of the records of the severable portion transferred within 90 days from the date of transfer.

(3) The transfer of records meets the approval of the predecessor and department and adequate information is furnished to meet the requirements.

c. Rescinded IAB 5/14/03, effective 6/18/03.

23.28(2) An *"organization," "trade"* or *"business"* as used in Iowa Code section 96.19(16)*"b"* is acquired if an employing unit acquires factors of an employer's organization, trade or business sufficient to constitute an entire existing going business unit as distinguished from the acquisition of merely assets from which a new business may be built. The question of whether an organization, trade or business is acquired is determined from all the factors of the particular case. Among the factors to be considered are:

a. The place of business.
b. The staff of employees.
c. The customers.
d. The good will.
e. The trade name.
f. The stock in trade.
g. The tools and fixtures.
h. Other assets.

23.28(3) Substantially all of the assets as used in Iowa Code section 96.19(16)*"b"* are acquired if an employing unit acquires substantially all of the assets of any employer which generate substantially all of the employment, except those retained incident to the liquidation of obligations.

23.28(4) A segregable and identifiable part of enterprise as used in Iowa Code section 96.7(3)*"b"* is acquired if an employing unit acquires factors of any employer's organization, trade or business sufficient to constitute an existing separable going business unit as distinguished from the acquisition of merely assets from which a new business may be built. The part of the business acquired, if considered separately, would have been liable under section 96.19(16)*"a."* The question of whether a distinct and severable portion is acquired is determined from all of the factors of the particular case. Among the factors to be considered are:

a. The place of business.
b. The staff of employees.
c. The customers.
d. The good will.
e. The trade name.
f. The stock in trade.
g. The accounts receivable.
h. The tools and fixtures.

23.28(5) *"Successor liability"* as used in Iowa Code chapter 96, and these rules, occurs for the acquiring employing unit when there is a transfer of the predecessor's assets or other physical components necessary to continue the operation of the enterprise or business to the successor employer and the successor employing unit must continue to operate the business to the same basic extent as if there had been no change in the ownership or control of the business or enterprise.

23.28(6) Successor liability will be found to occur. If an enterprise or business is leased to a covered employer and any party or entity purchases or assumes the covered employer's lease, or any party or entity acquires a new lease and substantially all of the assets of the covered employer, and the new lessee continues the operation of the enterprise or business to the same basic extent as though there had been no change in the ownership or control of the enterprise or business, such party or entity acquires the covered employer's experience.

23.28(7) The department will utilize the following general criteria when establishing successorship in specialized cases:

a. Where a covered employing unit is operating an enterprise or business under a lease agreement and it is terminated, there will be no transfer of the covered employing unit's experience unless the lessor takes over and continues to operate the enterprise or business in which case the lessor will be considered the successor to the covered employer's experience.

b. Where an enterprise or business is leased to a covered employing unit, and the lease agreement has terminated with the lessor acquiring a new lessee, the new lessee is not considered to be a successor to the experience of the predecessor lessee unless the new lessee acquires substantially all of the assets of the predecessor lessee and the new lessee continues the operation of the enterprise or business to the same basic extent as though there had been no change in the ownership or control of the enterprise or business.

c. A franchise agreement will be treated the same as lease agreement.

d. If the bankruptcy court closes an enterprise or business, the court becomes the agent for the bankrupt employer.

(1) Where the court closes the enterprise or business and starts liquidating procedures, the employer's account is placed in an inactive status subject to termination and no successorship or transfer of the employer's experience is involved, or

(2) If the court appoints a trustee or receiver to continue the operation of the enterprise or business, the account address will be corrected to include the name of the trustee or receiver for mailing purposes. If the trustee or receiver obtains a new federal identification number for this business, a new account number will be established for the trustee or receiver as a successor to the original enterprise or business. If the trustee or receiver sells the enterprise or business as a going enterprise, the new owner will be a successor to the predecessor's experience.

e. If a covered employer is forced out of business through foreclosure proceedings there will be no transfer of the employer's experience unless the mortgagee takes over the operation of the business or enterprise and continues it to the same basic extent as though there had been no basic change in the ownership control.

This rule is intended to implement Iowa Code sections 96.7(3)*"b,"* 96.8 and 96.19(16)*"b."*

871—23.29(96) Transfer of entire business.

23.29(1) *Notice of acquisition.*

a. Whenever any employing unit in any manner succeeds to or acquires from an employer either the organization, trade or business or substantially all the assets thereof, and continues such organization, trade or business, such employing unit shall notify the department for the purpose of accomplishing the transfer of the reserve account of the predecessor employer to the successor employing unit. Such notification must be in writing on Form 60-0126, Report to Determine Liability, and include the name and address of the predecessor, the date of acquisition, and the name and address of the successor. When such notice has been received or in the absence of the notice when necessary information establishing that the acquisition occurred has been received by the department, the actual contribution and benefit experience and taxable payrolls of the predecessor shall be transferred to the successor employing unit for determining its rate of contribution. Thereafter, benefits chargeable because of employment for such transferred organization, trade, or business shall be charged to the account of the successor. The predecessor must submit in writing a completed Form 60-0111, Employer Notice of Change.

b. Where one or more employing units have been reorganized, merged or consolidated into a single employing unit and the successor employing unit continues to operate such merged or consolidated enterprise, the employing units involved shall file change of ownership Forms 60-0111, Employer Notice of Change, and 60-0126, Report to Determine Liability, with the workforce development department within 30 days from the date of the transaction. In addition to Forms 60-0111 and 60-0126, all entities involved in the merger shall file with the workforce development department the articles of merger, or if there are no articles of merger, a statement advising that the merger has transpired.

(1) The predecessor business or businesses involved in the merger shall each file a final quarterly payroll report form as soon as possible after the merger has occurred but in no case later than 30 days after the close of the quarter in which the merger occurred.

(2) The successor entity shall indicate on Form 60-0126, Report to Determine Liability, whether or not the experience rates of all accounts are to be combined and the rate recomputed for the balance of the calendar year in which the merger took place.

23.29(2) *Contribution rate.* The successor's contribution rate for the remainder of the calendar year beginning with the date of acquisition shall be assigned as follows:

a. If the successor had no account prior to the transfer and the successor purchased the business of only one predecessor, or more than one predecessor with identical rates, the rate assigned will be the rate of the predecessor employer or employers.

b. If the successor had no account prior to the transfer and purchased the business of more than one predecessor on the same day, the final rate assigned will be a computed rate based on the combined experience of all the predecessor employers.

c. If the successor had an account prior to the transfer, the rate assigned will be the successor's existing rate. However, the successor may apply for a recomputed rate based on the combined experience of the predecessor or predecessors and the experience of the successor.

This rule is intended to implement Iowa Code section 96.7(2)*"b."*

871—23.30(96) Successorship—liability for contributions and payments in lieu of contributions.

23.30(1) Any employer who becomes a successor to an employer account shall be held liable for any unpaid contributions, reimbursable benefit payments, interest, penalties or costs which are owed to the department by the predecessor at the time of the transfer. An employer which is found to be a successor to a reimbursable account shall also be liable to reimburse the department for benefits paid after the date of acquisition that are based on wages paid by the reimbursable predecessor prior to the date of acquisition whether or not the successor has elected, or is eligible to elect, to become a reimbursable employer with respect to the successor's payroll.

23.30(2) Transfers under the Bulk Sales Act, uniform commercial code of Iowa, shall not be held by the department to be exempted from the provisions of Iowa Code section 96.7. The transferee shall be held a successor to the employer account of the transferor and liable for any unpaid contributions, reimbursable benefit payments, interest, penalty, and costs owed to the department by the transferor notwithstanding any agreement between the two parties pursuant to the Bulk Sales Act, provided the transferee continues to operate the business.

This rule is intended to implement Iowa Code section 96.7.

871—23.31(96) Transfer of segregable portion of an enterprise or business.

23.31(1) *Application and required information.*

a. The experience of a distinct and segregable portion of an organization, trade, or business shall be transferred to an employing unit which has acquired such portion only if the successor employing unit:

(1) Files with the department a written application, on Form 60-0126, Report to Determine Liability, or in letter form, within 90 days after the date of purchase;

(2) Submits necessary information establishing the separate identity of the accounts within 30 days after request is made by the department unless the time is extended for good cause shown; and

(3) Continues to operate the acquired portion of the business.

b. Necessary information establishing the separate identity of the account includes but is not limited to:

(1) Written agreement to the transfer by the predecessor. The predecessor's signature on Forms 68-0068 and 68-0065, The Report of Employer on Transfer of One of Two or More Employing Units, will be sufficient. (See 23.31(1)*"b"*(4), (5));

(2) Date of acquisition of the segregable portion;

(3) Date of commencement of the segregable portion by the predecessor;

(4) Report showing the names of employees, their social security numbers, and their wages attributable to the acquired portion of the business for the six calendar quarters including and immediately preceding the quarter in which the acquisition occurred. (Form 68-0065, The Report of Employer on Transfer of One of Two or More Employing Units.)

(5) Report showing the predecessor and successor name, address, account numbers, information showing the total taxable wages and benefit charges to be transferred by quarter, for the 20 calendar

quarters including and immediately preceding the date of the acquisition. (Form 68-0068, The Report of Employer on Transfer of One of Two or More Employing Units.)

c. It shall be the sole responsibility of the successor employer to determine whether or not to apply for a partial transfer of experience. An application for a partial transfer may be withdrawn in writing at any time prior to the department mailing notice that the transfer has been approved.

d. It shall be the sole responsibility of the predecessor employer to determine whether or not to grant the partial transfer of experience. Permission to grant the partial transfer of experience may be withdrawn in writing at any time prior to the department mailing notice that the transfer has been approved.

23.31(2) *Portion of reserve and payroll transferred.* When the requirements for partial transfer as defined in subrule 23.31(1) have been met, the transfer shall be made in accordance with one of the following:

a. If the predecessor's account has been in existence less than five years prior to the acquisition or purchase date (or more than five years when records are available), the information necessary to calculate future rates will be transferred; or

b. If the predecessor's account has been in existence more than five years (and records prior to five years are unavailable) and the acquired portion has also been in existence more than five years,

(1) The actual taxable wages, and benefit charges attributable to the acquired portion for the five-year period immediately preceding the date of acquisition shall be transferred, plus

(2) That portion of the predecessor's benefit charges for the period commencing with the beginning date of the predecessor's account and ending five years prior to the acquisition date equal to the ratio of the taxable wages attributable to the acquired portion for the 12 completed calendar quarters immediately preceding the acquisition date to the total taxable wages reported by the predecessor for the same 12-quarter period, and

(3) The individual wage records attributable to the acquired portion (as supplied on Form 68-0065); or

c. If the predecessor's account has been in existence more than five years but the acquired portion came into existence within the last five years, the actual taxable wages, benefit charges, and individual wage records (as supplied on Form 68-0065) attributable to the acquired portion shall be transferred; or

d. In the case of governmental transfers in addition to the items listed above, contributions and interest earned must be transferred for all years.

23.31(3) *Future benefit charges based on wages paid by the predecessor prior to the acquisition or purchase date.* The successor employer will receive future benefit charges based on the wage credits transferred to said successor's account for the six-quarter period immediately preceding the acquisition date plus any benefit charges based on wages attributable to the acquired portion prior to the six-quarter period on claims already filed on the date of the acquisition.

23.31(4) *Notification of approval or denial of transfer and appeals.*

a. Upon receipt of application (see subrule 23.31(1)) and accompanying information as required, the department shall issue a determination approving or denying the partial transfer. The determination approving a partial transfer will include notice to both parties as to their contribution rate for the current year.

b. If the department finds in any case that the acquisition of a business or a severable portion thereof was made solely or primarily for the purpose of obtaining a more favorable rate of contribution, the transfer of the reserve account shall not be approved. An acquisition shall be deemed to have been solely or primarily for such purpose if the department finds an absence of any reasonable business purpose for the acquisition other than a more favorable contribution rate.

c. Any determination made hereunder denying a partial transfer shall become conclusive and binding upon both the predecessor and successor unless one or both of them file an appeal. For the specific procedure and requirements for perfecting an appeal of an employer liability determination see rules 23.52(96) to 23.56(96).

23.31(5) *Liability of successor for contribution.* Any individual or organization, whether or not an employing unit, which in any manner acquires the organization, trade or business or substantially all of

the assets thereof, and is held to be a successor, shall be liable for the payment of contribution, interest and penalty, due or accrued and unpaid by such predecessor employer, at the time of acquisition or purchase, if the department concludes that such contributions cannot be collected from the predecessor on the portion of such organization, trade or business acquired by the successor.

This rule is intended to implement Iowa Code section 96.7(3).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.32(96) Mandatory and prohibited successorships.

23.32(1) This rule applies to the mandatory successorship in Iowa Code section 96.7(2)*"b"*(2) and the prohibited successorship in Iowa Code section 96.7(2)*"b"*(3). If one employing unit receives the organization, trade or business, or a portion thereof of an employing unit and there is substantially common ownership, management or control of the two, the attributable unemployment experience will be transferred. This section of the law does not require a transfer of substantially all of the assets nor does it require the transferred portion to be segregable or identifiable. The acquiring employer must continue to operate the organization, trade or business or must transfer operation to an entity with substantially common ownership, management or control with the acquiring entity. Mandatory successorship also applies when the acquirer was not an employing unit prior to the transfer.

a. A transfer of staff and the business activity of that staff to an acquiring employer unit which continues to operate the portion of the business will establish mandatory successor liability.

b. The mandatory and prohibited successorships contained in Iowa Code sections 96.7(2)*"b"*(2) and (3) apply to corporations, limited liability companies, government or governmental subdivisions or agencies, business trusts, estates, trusts, partnerships, sole proprietorships or associations, or any other legal entity as defined in Iowa Code chapter 96.

c. "Substantially common ownership, management or control" is determined from the facts of a particular case. Among the factors to be considered are:

(1) The authority to make policy decisions.

(2) The authority to perform personnel actions.

(3) Direction and control of the day-to-day operations.

(4) Financial investment.

(5) Substantial or complete ownership by the same legal entity or entities.

(6) Ability to conduct or liability for financial transactions on behalf of the business.

(7) Authority to commit the business assets.

(8) Common management which may include direction or overall supervision by an individual or group of individuals.

d. For a mandatory full successorship the tax rate shall be established as provided in subrule 23.29(2), and for a mandatory partial successorship the tax rate shall be established as provided in subrule 23.32(4).

23.32(2) In determining whether or not an acquiring entity continues to operate an organization, trade or business as used in Iowa Code section 96.7(2)*"b"*(2), the following rules apply.

a. The acquiring entity continues the ongoing business operation (taking into account any seasonal or prior operational pattern), and continues the same business activity as the prior employer. A temporary cessation of the business activity by the acquiring entity will not constitute a discontinuance of the business.

b. The acquiring entity, not having operated the business, reassigns or otherwise transfers the operation of the business to a third-party entity that has substantially common ownership, management or control with the acquiring entity. The third party is considered to be continuing the operation of the original entity.

23.32(3) Prohibited successor liability. Successor liability is prohibited when the department finds that a legal entity that is not subject to Iowa Code chapter 96 at the time of acquisition (regardless of whether or not common ownership, management or control exists) acquires an organization, trade or business solely or primarily for the purpose of obtaining a lower rate of contribution. Factors to be considered include:

a. The existing employer account has a tax rate less than would be assigned to a new employer,

b. The cost of acquiring the organization, trade or business as compared with any potential savings in contributions costs,

c. The acquiring entity substantially changed the organization, trade or business after a short period of time, and

d. A substantial number of new employees were hired to perform duties unrelated to the organization, trade or business operated prior to the acquisition.

23.32(4) When a mandatory transfer of a portion of a business occurs, the successor's experience and contribution rate will be determined as follows:

a. The experience transferred to the acquiring employing unit will be based on the percentage of employees moving from the predecessor to that unit.

(1) The percentage will be computed by comparing the number of employees on the successor's first quarterly report covering a complete calendar quarter to the average number of employees on the four complete quarterly reports filed by the predecessor immediately preceding the transfer. The average number of employees will be computed using only the predecessor's reports that have wages paid during those four quarters.

(2) Using this percentage, taxable wages and benefit charges, commencing with the beginning date of the predecessor's account, will be transferred from the predecessor's account to the successor's account.

b. If the successor had no account prior to the transfer, the rate assigned will be the rate of the predecessor for the remainder of the calendar year beginning with the date of acquisition.

c. If the successor already had an account prior to the transfer, the rate for the balance of the year in which the transfer took place will be recomputed by combining the transferred experience with the employer's own experience as of the last computation date.

d. For the years following the year of acquisition, the rates will be computed using the experience of the employer combined with the transferred experience.

e. Future benefit(s) will be charged to the base period employer who reported the base period wages.

f. The department will issue a notification when the partial transfer has been completed. The determination will include notice to both parties as to their contribution rate for the current year.

g. Any rate determination resulting from a partial transfer will become final unless one or both of the parties files an appeal. For the specific procedure and requirements for perfecting an employer liability determination appeal, see rule 23.52(96).

h. In the case of governmental transfers in addition to the items listed above, contributions and interest earned must be transferred for all years.

23.32(5) Penalty contribution rate. The department may assess a penalty contribution rate of 2 percent for the current year and two subsequent years for an employer that the department finds has attempted to manipulate and circumvent the proper unemployment tax rate as provided in Iowa Code sections 96.7(2)*"b"*(2) and (3) by deliberate nondisclosure of a material fact.

a. The employer will be notified of the penalty contribution rate on Form 95-5306, Notice of Unemployment Insurance Contribution Rate.

b. If, after a liability determination has been issued, the department discovers, based upon new facts not available to the department at the time the determination was made, that a previously nonliable entity acquired a business solely or primarily to obtain a lower tax rate, the department will amend the original determination and assign a new employer rate and may provide a penalty contribution rate.

c. Interest will accrue on unpaid penalty contributions in the same manner as on regular contributions.

This rule is intended to implement Iowa Code sections 96.7(2)*"b"* and 96.16(5).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.33 to **23.35** Reserved.

871—23.36(96) Predecessor—contribution rates for winding down a business. In the case where a predecessor has transferred its organization, trade, or business, or substantially all assets, to a successor in interest and the predecessor employer continues to operate a part of the business in order to wind down or close the business after the date of transfer, the predecessor shall retain the same account number but will recompute the eligibility year, determination date, effective date, law citation and tax rate to that of a newly covered employer. For the purposes of this rule, the term "wind down wages" may exclude wages earned before the sale or transfer that were paid in the four consecutive quarters after the quarter in which the sale or transfer occurred.

This rule is intended to implement Iowa Code sections 96.8(1) and 96.8(4)*"a."*

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.37(96) Adjustments and refunds of contributions.

23.37(1) Whenever any employer discovers that the contribution report submitted is incorrect resulting in overpayment of contributions due and owing, such employer may file an application for credit allowance or refund. If the department discovers that the contribution report submitted by any employer is incorrect resulting in overpayment of contribution, it may on its own initiative refund or make a credit allowance. No refund or credit allowance will be made after three years from the date on which the overpayment was made. The Form 68-0061, Employer's Wage Adjustment Report, shall be filed by paper or electronically to show corrections to the individual wage amounts, corrections of grand totals (total wages, taxable wages and contributions), and a full explanation for the adjustment. Adjustment shall be made by the department in the form of credit allowance or refund as provided in subrule 23.37(3) equal to that portion of contributions erroneously paid which exceeds the benefits paid to claimants as a direct result of the employer's erroneous report.

23.37(2) If the contribution and wage report first submitted by an employer understates the amount of wages paid for a given period, the employer will file using a Form 68-0061, Employer's Wage Adjustment Report, for the period and make payment covering all additional contributions, penalty and interest due.

a. If it is apparent, upon examination of any regular or supplemental contribution report or Form 68-0061, Employer's Wage Adjustment Report, that a greater contribution than is required by law has been paid, the department may, within three years from the date of such overpayment, make an adjustment and issue a credit adjustment memorandum for such overpayment.

b. If it is not apparent from the examination of any regular or supplemental contribution report or Form 68-0061, Employer's Wage Adjustment Report, that a contribution greater than that required by law has been made, any employer or employing unit claiming a credit adjustment shall file with the department a written application for such adjustment within three years from the date on which such overpayment was made. Such credit adjustment shall be granted only after a review of the application which will set forth such information in the matter as may be required. If, after such review, the adjustment is found to be in order, the department shall issue a credit adjustment or refund for the overpayment.

23.37(3) The amount of the credit will be deducted from the contributions in the employer's account and credited to any outstanding account balance until the credit is used or canceled in accordance with these rules. If the employer fails to utilize the credit as provided above, the department shall, three years from the date of issuance, cancel the credit and show it as a nonrefundable credit. The department, upon request of the employer or on its own initiative, may issue a refund of the overpayment. The state comptroller is responsible for the issuance of the warrant.

23.37(4) When an employer requests a refund or credit of contributions paid due to an erroneous reporting of wages, the refund or credit shall be reduced by the amount of benefits paid and charged to the employer as a result of the erroneous wages.

23.37(5) All grounds and facts alleged in support of a claim for refunds or credit shall be clearly set forth. The employing unit shall furnish such proof in support of the claim as may be reasonably

necessary at the discretion of the department to support the validity and the amount of the claim and the fact that the employing unit making the application for refund or credit is legally entitled to it.
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.38(96) Denial of claim for refund or credit. A claim shall be denied if an employing unit within 30 days after written demand by the department fails to submit reasonable proof to support the validity and amount of the claim or fails to request an extension of time in which to submit the required information.

871—23.39(96) Issuance of a duplicate credit memo. Rescinded IAB 5/14/03, effective 6/18/03.

871—23.40(96) Computation of rates for private sector employer.

23.40(1) *Experience rating.* An employer's experience rate shall be computed by dividing the average of all benefits charged to an employer during the five periods of four consecutive calendar quarters immediately preceding the computation date by the employer's five-year average annual taxable payroll to arrive at the benefit ratio. This ratio shall be applied to the appropriate rate table, as determined by the department, to determine the employer's contribution rate for the next calendar year. Indian tribal contributory employers shall be considered private sector employers for the purpose of computing their contribution rate.

23.40(2) *Administrative contribution surcharge.*

a. For calendar years 2002 and 2003, each employer except a governmental entity and a 501(c)(3) nonprofit organization will have an administrative contribution surcharge added to the contribution rate. The administrative contribution surcharge shall be a percentage of the taxable wage base in effect for the rate year following the computation date which is equal to one-tenth of 1 percent of the Federal Unemployment Tax Act (FUTA) taxable wage base in effect on the computation date. The surcharge will be a three-place decimal number which is added to the contribution rate. The surcharge formula will provide a target revenue level of no greater than $6,525,000 annually and the percentage surcharge will be capped at a maximum of $7 per employee.

b. A portion of each payment received from an employer shall be considered administrative contribution surcharge and shall be credited to the administrative contribution surcharge fund. The administrative contribution surcharge shall be collectible, and interest shall accrue on unpaid surcharge at the same rate as on regular contributions.

c. The portion of the employer's payment credited to the administrative contribution surcharge fund shall not be certified to the Internal Revenue Service as contributions for which the employer may take credit against the employer's federal unemployment tax (FUTA-Form 940).

d. The administrative contribution surcharge fund shall be a separate and distinct fund from the unemployment compensation fund. Interest earned on the moneys in the administrative contribution surcharge fund shall be credited to the administrative contribution surcharge fund. Moneys in the administrative contribution surcharge fund shall be appropriated by the general assembly.

23.40(3) *Temporary emergency surcharge.* If it becomes necessary to implement a temporary emergency surcharge on all employers, except zero rated employers, governmental employers, and 501(c)(3) nonprofit organizations, for any quarter to pay interest on moneys borrowed from the federal government to pay unemployment insurance benefits, the emergency surcharge shall be collected and credited in the following manner:

a. The emergency surcharge rate shall be added to the employer's regular contribution (tax) rate for the quarter. The add-on rate shall be a uniform percentage of each affected employer's regular contribution rate rounded to the nearest one-hundredth of a percent. The affected employers will be notified by the department of the surcharge by any appropriate means available at the time.

b. A portion of each payment that is received from an employer for a quarter in which the emergency surcharge is in effect shall be considered as being temporary emergency surcharge and shall be credited to the temporary emergency surcharge fund.

c. The portion of the employer's payment credited to the temporary emergency surcharge fund shall not be certified to the Internal Revenue Service as contributions for which the employer may take credit against the employer's federal unemployment tax (FUTA-Form 940).

d. The temporary emergency surcharge shall be used to pay the interest accrued on the trust fund money advanced to the department of workforce development by the federal government.

e. The director of the department of workforce development shall prescribe the manner and the amount of the surcharge to be collected.

This rule is intended to implement Iowa Code sections 96.7(2), 96.7(11), 96.7(12) and 96.19(8).

871—23.41(96) Computation date defined. The computation date for the succeeding year's contribution rate shall be July 1. The rate computation shall include the taxable wages reported for the quarters prior to and ending on June 30 immediately preceding the computation date and benefit charges based on benefit warrants issued on or before June 30 immediately preceding the computation date. Delinquent reports received after September 30 immediately following the computation date shall not be used for the succeeding year's rate computation.

This rule is intended to implement Iowa Code section 96.19(8).

871—23.42(96) Crediting of interest earned on the unemployment trust fund. Interest received on moneys deposited with the Secretary of the Treasury of the United States shall be credited to the unemployment compensation fund.

This rule is intended to implement Iowa Code section 96.9(2)*"c."*

871—23.43(96) Charging of benefits to employer accounts.

23.43(1) *How charged.* Benefits paid to an eligible claimant shall be charged against the base period wage credits in the same inverse chronological order as the wages on which the wage credits are based were paid to the claimant.

23.43(2) *Formula for charging employer accounts.*

a. Wage credits in the most recent quarter of the base period will be used first and when wage credits in this quarter are exhausted, wage credits for the next most recent quarter will be used until each of the four quarters in the base period is exhausted or until the claimant is paid an amount not to exceed the claimant's maximum benefit amount.

b. Each employer who has wage credits in the quarter of the base period currently being used will be charged the employer's proportional share of each payment. The proportional share to be charged to each employer in the quarter will be the employer's percentage of the total wage credits in the quarter.

23.43(3) *Rule of two affirmances.*

a. Whenever an administrative law judge affirms a decision of the representative or the employment appeal board of the Iowa department of inspections and appeals affirms the decision of an administrative law judge, allowing payment of benefits, such benefits shall be paid regardless of any further appeal.

b. However, if the decision is subsequently reversed by higher authority:

(1) The protesting employer involved shall have all charges removed for all payments made on such claim.

(2) All payments to the claimant will cease as of the date of the reversed decision unless the claimant is otherwise eligible.

(3) No overpayment shall accrue to the claimant because of payment made prior to and during the period in which the department is processing the reversal decision.

23.43(4) *Supplemental employment.*

a. An individual, who has been separated with cause attributable to the regular employer and who remains in the employ of the individual's part-time, base period employer, continues to be eligible for benefits as long as the individual is receiving the same employment from the part-time employer that the individual received during the base period. The part-time employer's account, including the reimbursable employer's account, may be relieved of benefit charges. On a second benefit year claim

where the individual worked only for the part-time employer during the base period and the lag quarter, the part-time employer shall not be considered for relief of benefit charges with the onset of the second benefit year. It is the part-time employer's responsibility to notify the department of the part-time employment situation so the department may render a decision as to the availability of the individual and benefit charges. The individual is required to report gross wages earned in the part-time employment for each week claimed and the wages shall be deducted from any benefits paid in accordance with Iowa Code section 96.3(3).

b. An individual who voluntarily quits without good cause part-time employment and has not requalified for benefits following the voluntary quit of part-time employment, yet is otherwise monetarily eligible for benefits based on wages paid by the regular or other base period employers, shall not be disqualified for voluntarily quitting without good cause the part-time employer. The individual and the part-time employer which was voluntarily quit without good cause shall be notified on Form 65-5323 or 60-0186, Decision of the Workforce Development Representative, that benefit payments shall not be made which are based on the wages paid by the part-time employer, and benefit charges shall not be assessed against the part-time employer's account; however, once the individual meets the requalification requirements following the voluntary quit without good cause of the part-time employer, the wages paid in the part-time employment shall be restored for benefit payment and charging purposes as determined by applicable requalification requirements.

23.43(5) *Sole purpose.* The claimant shall be eligible for benefits even though the claimant voluntarily quit if the claimant left for the sole purpose of accepting an offer of other or better employment, which the claimant did accept, and from which the claimant is separated, before or after having started the new employment. No charge shall accrue to the account of the former voluntarily quit employer.

23.43(6) Reserved.

23.43(7) *Department-approved training.* A claimant who qualifies and is approved for department-approved training (see rule 871—24.39(96)) shall continue to be eligible for benefit payments. No contributing employer shall be charged for benefits which are paid to the claimant during the period of the department-approved training. The relief from charges does not apply to the reimbursable employer that is required by law or election to reimburse the trust fund, and the employer shall be charged with the benefits paid.

23.43(8) *Ten times the weekly benefit amount in insured work requalification.*

a. In order to meet the ten times the weekly benefit amount in insured work requalification provision, the following criteria must be met:

Subsequent to leaving or refusing work, the individual shall have worked in (except in back pay awards) and been paid wages equal to ten times the claimant's weekly benefit amount.

b. An employer's account shall not be charged with benefit payments to an eligible claimant who quit such employment without good cause attributable to the employer or who was discharged for misconduct or who failed without good cause either to apply for available, suitable work or to accept suitable work with that employer but shall be charged to the balancing account.

c. The requalification and transfer of charges shall occur for the employer if the requalifying employment is earned with an out-of-state covered employer. The transfer of charges shall be made to the balancing account.

d. Periods of insured employment with separate employers may be joined to collectively equal ten times the individual's weekly benefit amount when requalification cannot be accomplished by an individual insured employer. The employer from whom the individual left work, was discharged or with whom the individual failed to apply or accept suitable work, will not accrue any charges.

e. Before benefits can be paid or the transfer of charges can occur, sufficient evidence must be present to establish the fact that the criteria in subrule 23.43(8), paragraph *"a,"* has been met. Verification of employment may be completed through the records of the department or by using any method establishing proof of the necessary wage credits, including the following:

(1) An employment verification form, 60-0227, is an affidavit prepared in duplicate stating: the insured employer's name, mailing address, the starting date of employment, and wages paid

subsequent to that date. The form must be signed by the claimant alleging that the facts are correct. Any misrepresentation in the form may result in overpayment, fraud charges and administrative penalty any or all thereof. A copy of the form must be mailed to the employer or employers for verification. The employer should review the information on the form and certify that it is either correct or in error. If the information is incorrect, the employer should give the proper information. If the employer fails to return the form within five days of date mailed, the information on the form will be presumed to be correct.

(2) Employment check stubs may be used in conjunction with the employment verification form, 60-0227, to indicate the requalifying period.

23.43(9) *Combined wage claim transfer of wages.*

a. Iowa employers whose wage credits are transferred from Iowa to an out-of-state paying state under the interstate reciprocal benefit plan as provided in Iowa Code section 96.20 will be liable for charges for benefits paid by the out-of-state paying state. No reimbursement so payable shall be charged against a contributory employer's account for the purpose of Iowa Code section 96.7, unless wages so transferred are sufficient to establish a valid Iowa claim, and such charges shall not exceed the amount that would have been charged on the basis of a valid Iowa claim. However, an employer who is required by law or by election to reimburse the trust fund will be liable for charges against the employer's account for benefits paid by another state as required in Iowa Code section 96.8(5), regardless of whether the Iowa wages so transferred are sufficient or insufficient to establish a valid Iowa claim. Benefit payments shall be made in accordance with the claimant's eligibility under the paying state's law. Charges shall be assessed to the employer which are based on benefit payments made by the paying state.

b. The Iowa employer whose wage credits have been transferred and who has potential liability will be notified on Form 65-5522, Notice of Wage Transfer, that the wages have been transferred, the state to which they have been transferred, and the mailing address to which a protest of potential charges may be mailed. This protest must be postmarked or received by the department within ten days of the date the Form 65-5522 was mailed to be considered as a timely protest of charges. If the protest from either the reimbursable or contributory employer justifies relief of charges, charges shall go to the balancing account.

c. Requests received from the paying state for amounts in excess of an amount equal to potential charges of an Iowa claim will not be charged to the Iowa employer, except for reimbursable employers.

d. When Iowa is the paying state on an interstate claim and Iowa wage credits are insufficient to have a valid Iowa claim, charges shall not be made against the Iowa employer's account but shall be charged to the balancing account, except for reimbursable employers.

23.43(10) Reserved.

23.43(11) *Extended benefits.*

a. Fifty percent of the amount of each week of extended benefits paid to an individual in accordance with rule 871—24.46(96) shall be charged against the account of the employer which is chargeable for the extended benefits; however, 100 percent of the amount of each week of extended benefits paid to an individual shall be charged against the account of the Indian tribal and governmental contributory or reimbursable employer which is chargeable for the extended benefits.

b. The lack of a one-week waiting period prohibits this state from receiving a payment from the U.S. Department of Labor for 50 percent of the amount of the first week of extended benefits paid to an individual. This amount shall not be charged against the account of the employer which is chargeable for the extended benefits unless the employer is a nonprofit reimbursable employer but shall be charged against the balancing account.

c. In the event that a payment from the U.S. Department of Labor for 50 percent of any week of extended benefits paid to an individual is reduced under an order issued under Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, the amount of the reduction shall not be charged against the account of the employer which is chargeable for the extended benefits unless the employer is a nonprofit reimbursable employer but shall be charged against the balancing account.

23.43(12) *Charging of benefits paid to individuals employed by two or more employers.*

a. Whenever wage reports submitted to the department show the employment of an individual by more than one employer in the same calendar quarter, benefits shall be charged to each employer's account in the same proportion as wages paid in the quarter.

b. Benefits for partial unemployment shall be charged in the same manner as benefits for total unemployment, except that no charges shall be made against the account of the base period contributory or reimbursable employer which continues to employ the individual on the same basis that the employer employed the individual during the individual's base period.

23.43(13) *Government contributory charges.* For the purpose of determining the base rate for government contributory employers, a percentage of all benefits that are paid but are not chargeable to employer accounts because of various provisions of the law, will be considered as belonging to government contributory employers. The percentage of the nonchargeable benefits considered to be attributable to government contributory employers for each calendar year will be determined by the ratio of the benefits actually charged to government contributory accounts for the year to the total benefits charged to all contributory accounts for the year.

23.43(14) *Removal of benefit charges upon the sale or transfer of a clearly segregable part of an employer's business or enterprise when the acquiring employer does not receive a partial transfer of experience.* Benefits based on wages earned with the transferring employer, paid to an individual who worked in and was paid wages for work with the acquiring employer shall be transferred to the balancing account. The transferring employer must protest this issue on the Notice of Claim, Form 65-5317, in a timely manner to receive relief from the charges. The relief of charges shall apply to both contributory and reimbursable employers.

23.43(15) *Disaster relief.* An employer shall not be charged with benefits for unemployment that is directly caused by a disaster declared by the president of the United States, pursuant to the federal Disaster Relief Act of 1974, if the individual would have been eligible for disaster unemployment assistance with respect to that unemployment but for the individual's receipt of regular benefits. The employer may protest the charges on the Notice of Claim, Form 65-5317, or the Quarterly Charge Statement. The employer must protest the charges within 30 days after the date of mailing of the Quarterly Charge Statement.

This rule is intended to implement Iowa Code sections 96.3(7), 96.5(1), 96.6(2), 96.7, 96.8(5), 96.9(5), 96.11(1), 96.16(4), and 96.29.

871—23.44(96) Benefits payments.

23.44(1) Overpayments. If a claimant is overpaid benefits, the employer will be relieved of benefit charges to such employer's account.

23.44(2) The employer shall not be relieved of benefit charges for a payment of back pay until the amount of the overpayment is recovered by the department.

23.44(3) Option of reimbursable credit or refund for an overpayment. The department shall credit the account of the reimbursable employer for overpayments. However, the employer may request a refund in those cases where the employer determines that it cannot use the credit against future charges within a reasonable period of time.

This rule is intended to implement Iowa Code sections 96.7(3), 96.11(1) and 96.20(2).

871—23.45 Reserved.

871—23.46(96) Termination of coverage. Rescinded IAB 5/5/10, effective 6/9/10.

871—23.47(96) Termination of accounts because of no wage reports.

23.47(1) If an employer discontinues business or continues business without employment, the employer may request that the employer's account be placed in an inactive status. Upon determination of an inactive status, the department shall notify the employer that the employer's account has been

placed in an inactive status and that the employer is not required to file quarterly reports. However, the employer must notify the department if the employer resumes paying Iowa wages.

23.47(2) If the department finds that an employer has discontinued business or is no longer paying wages, the department may on its own motion place the account in an inactive status. However, the employer must notify the department if the employer resumes paying Iowa wages.

23.47(3) If prior to termination, an inactive account is found to have paid wages in any quarter, the employer account shall be reactivated, reports shall be secured for all quarters the account was inactive, including no wage reports for quarters for which there was no employment, and the account shall receive an experience rating; provided, the account has been in existence long enough to qualify for an experience rating.

23.47(4) If, on the rate computation date, the department finds that an employer has not paid wages during the eight consecutive calendar quarters immediately preceding the computation date, the employer's account shall be terminated effective the January 1 following the computation date. However, if the employer pays wages after the computation date and prior to the following January 1, the employer's account shall not be terminated, and the employer will receive an assigned rate or an experience rating.

23.47(5) If an employer has filed eight consecutive reports with zero wages, the account may be placed in inactive status.

This rule is intended to implement Iowa Code sections 96.7(2)*"c"* and *"d"* and 96.8(4)*"b."*
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.48(96) Previously covered employers. If a contributory employer's account has been properly terminated and the employer is again determined liable or a reimbursable employer again elects to be contributory, the employer shall be treated the same as a newly covered employer, except the employer will not receive a new account number. The employer's wage information prior to the termination will not be used for tax rate or taxable wage calculations.

This rule is intended to implement Iowa Code sections 96.7 and 96.8.
[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.49 and **23.50** Reserved.

871—23.51(96) Payments in lieu of contributions.

23.51(1) Each nonprofit organization which has been approved to make payments in lieu of contributions shall be billed each quarter for benefits paid during such quarter.

23.51(2) The payments to the unemployment fund which are required by Iowa Code section 96.7 for those employers who elect to reimburse the department shall be in an amount equal to the regular benefits and one-half of the extended benefits paid and charged to such employer's account. Government and Indian tribal reimbursable employers will be charged all of the extended benefits paid.

This rule is intended to implement Iowa Code section 96.8(5).

871—23.52(96) Employer liability appeal.

23.52(1) An initial employer liability determination including employer status and liability, assessments, rate of contributions, successorships, worker's status, and all questions regarding coverage of a worker or group of workers may be appealed to the department of workforce development for a hearing before an administrative law judge with the department of inspections and appeals.

23.52(2) The appeal shall be in writing stating:

a. The name, address and Iowa employer account number of the employer.

b. The name and official position of the person filing the appeal.

c. The decision which is being appealed.

d. The grounds upon which the appeal is based.

23.52(3) The appeal shall be addressed or delivered to: Department of Workforce Development, Tax Bureau, 1000 East Grand Avenue, Des Moines, Iowa 50319. The employer shall provide adequate

postage on appeals filed by mail. Appeals transmitted by facsimile that are received by the tax bureau after 11:59 p.m. central time shall be deemed filed as of the next regular business day.

23.52(4) Unless otherwise required, all determinations by the tax bureau will be sent by regular mail to the last-known address of the employer. The determination will be dated and the employer or other interested party shall have 30 days from the mailing date printed on the notice to appeal the determination. The employer has 15 days to appeal a Notice of Reimbursable Benefit Charges, Form 65-5324.

23.52(5) If the department concludes, upon reviewing an appeal, that the original determination is correct, the tax bureau may write to the employer and further explain the decision. If the employer still desires a hearing before an administrative law judge, the employer should notify the department within 30 days of the date of the letter from the department.

23.52(6) Upon receipt of a request for hearing, the tax bureau will ask the department of inspections and appeals to schedule a hearing for the employer. A copy of the request will be mailed to the employer. A copy of the file containing all relevant information regarding the issue of the appeal shall be forwarded to the administrative law judge. Documents that may be sent to the administrative law judge include a copy of the disputed decision, the employer's original letter of appeal, all relevant correspondence from the department, and the employer's letter requesting a hearing. All employer liability appeals shall be heard by an administrative law judge and shall be scheduled for hearing at the earliest possible date. Procedures for employer liability hearings are set out in rule 871—26.5(17A,96).

23.52(7) In those cases in which the department finds that a genuine controversy exists or has existed regarding an employing unit's liability for contributions on all or a part of its employees or, a rate appeal or other employer liability question and the case has been resolved against such employing unit, then no interest or penalty will accrue from the date of such controversy between the department and the employing unit until 30 days after the decision becomes final.

871—23.53(96) Rate appeal and eligibility decision reversal.

23.53(1) An employer who appeals a rate notice or corrected rate notice within 30 days following the procedures outlined in rule 23.52(96) may have its rate recomputed based upon the reversal of a benefit eligibility decision under the following circumstances:

a. An employer may appeal on the grounds that benefit charges against the employer's account have been reversed by a decision issued subsequent to the rate computation date. The department will investigate and remove benefit charges, which have been reversed by a subsequent decision, from the computation and will issue a corrected rate notice to the employer.

b. The employer may appeal on the grounds that benefits charged against the employer's account may be reversed by a decision to be issued on a pending claim or charge-back appeal. The employer's rate will not be recomputed. However, the rate will not become final and the appeal may be reopened by the employer, in writing upon receipt of a decision reversing the allowance of benefits or relieving the employer of charges provided that the request to reopen the appeal is submitted within 30 days of the date of the next rate notice following the date of the decision. The charges will be removed from the computation of the original rate and a corrected rate notice will be issued. The employer must pay any contributions that become due at the disputed rate prior to the receipt of the decision reversing the benefit charges; however, a refund of any overpayment of contributions and interest paid by the employer as a result of the recomputation of the rate will be issued, subject to the three-year statute of limitations set out in Iowa Code section 96.14(5).

c. The employer's payment of contributions at the disputed rate in the circumstances described in 23.53(1)*"b"* will not be an acquiescence of the disputed rate.

d. The employer, in the circumstances described in 23.53(1)*"b,"* must file a separate appeal of each rate notice received that contains the disputed benefit charges. If the employer does not file a timely appeal of each affected rate notice, any appeal filed following receipt of a decision reversing the allowance of benefits will be considered as applying only to rate notices that were timely appealed and to the next rate notice.

e. If the employer appeals on the grounds that the benefits charged against the employer's account were paid to an employee who was still working for the employer in the same employment as in the

base period of the claim, the department will remove the charges and will issue a corrected rate notice. However, the employer's appeal must have been made within 30 days of the date on the first rate notice received that included any of the disputed charges. Provided further that the issue of charging of benefits had not been previously adjudicated in either an appeal of the original claim notice or an appeal of a quarterly benefit charge statement.

23.53(2) Reserved.

871—23.54(96) Payment of disputed assessments.

23.54(1) Payment of a disputed assessment is held to be an acquiescence in the assessment only when a timely appeal is not filed.

23.54(2) An employing unit which has appealed a determination of liability, or a payment of contributions due, shall file Form 65-5300, Employer's Contribution and Payroll Report, for all quarters for which the employer is held liable regardless of any appeal. Such reports are to be marked by the employer "Appeal Filed" and submitted with full payment of the disputed assessment, without payment or with a payment in the amount estimated to be owed by the employing unit.

871—23.55(96) Burden of proof.

23.55(1) The burden of proof in all employer liability cases shall rest with the employer.

23.55(2) The burden of proof shall rest with an employing unit which employs any individual during any calendar year but which considers itself not an employer subject to the Act, to establish that it is not an employer subject to the Act by presenting proper records, including a record of the identity of the employees, number of individuals employed during each week, and the particular days of each week on which services have been performed, and the amount of wages paid to each employee.

23.55(3) The burden of proof in successorship and partial successorship cases for determinations and appeals shall rest with the employer that is appealing the determination of the department.

871—23.56(96) Informal settlement.

23.56(1) Pursuant to Iowa Code chapter 17A a controversy may, unless precluded by statute, at the discretion of the department be informally settled by mutual agreement of the department of workforce development and the person or employer who is or is about to be engaged in the controversy with the department. The settlement shall be effected by a written statement reciting the subject of the controversy and the proposed solution mutually agreed upon by the parties including a statement of the action to be taken, or to be refrained from, by each of the parties. The informal settlement shall constitute a waiver, by all parties, of the formalities to which they are entitled under the terms of Iowa Code chapter 17A, with respect to the specific fact situation which is the subject of the controversy.

Either party may initiate a proposal for informal settlement of the controversy by communicating a proposal to the other party before the contested hearing is convened.

23.56(2) If the parties agree to a settlement, the written statement shall be presented to the administrator of the division of unemployment insurance services for review and approval.

23.56(3) In the event a settlement is reached in a case which has been appealed to the courts, then the formal settlement will be presented to the appropriate district court. If an assessment of contributions or a decision upon which an assessment is based has become final without appeal, then the actual established contribution may be compromised by agreement of the parties and submission to the district court pursuant to Iowa Code section 96.14(5). Doubtful collectibility as contained in section 96.14(5) includes tax debts which are doubtful as to validity or as to collectibility. The department is not required to enter into any informal settlement or compromise with regard to any employer liability determination and may or may not do so at its own discretion.

871—23.57(96) Interest and penalty on contributions paid with adjustments submitted by employer.

23.57(1) If an employer, on its own motion, submits an adjustment for an error made on a previous report and pays any additional contributions due on the adjustment when the employer submits the

adjustment, no interest on the additional contributions will be charged if it is shown to the satisfaction of the department that the error on the original report and subsequent late payment of the contribution due on the adjustment was not the result of negligence, fraud, intentional disregard of the law or rules of the department.

23.57(2) If an employer submits an adjustment without payment, and payment is due, such employer will be assessed for the additional contributions plus interest as provided by law.

871—23.58(96) Assessment of unpaid contributions, interest and penalty. Rescinded IAB 5/14/03, effective 6/18/03.

871—23.59(96) Determination and assessment of estimated contributions and errors in reporting.

23.59(1) If the department finds from the examination of the employer's reports or account that the contributions have been underpaid because of a department error in assigning the contribution rate, the additional contributions shall be paid within 30 days after the department notifies the employer; however, no interest or penalty will accrue until 30 days after the notification.

23.59(2) Assessment—failure to make return.

a. If any employing unit fails to make a return as required the department shall make an estimate based upon any information in its possession or that may come into its possession of the amount of wages paid for employment in the period or periods for which no return was filed upon the basis of such estimates shall compute and assess the amounts of employer contributions payable by the employing unit together with interest and penalty.

b. Whenever the department determines that the collection of contributions from an employer is in jeopardy and the employer has failed to file the necessary reports of wages paid for the quarter for which such contributions are due and payable or have been declared due and payable prior to the reporting date set out in rule 23.8(96), the department shall prepare estimated reports.

c. Such estimates may be made by authorized personnel in the tax bureau and shall be referred to the collection unit where Form 68-0138, Notice of Jeopardy Assessment, shall be prepared.

This rule is intended to implement Iowa Code section 96.7.

871—23.60(96) Accrual of interest and penalties.

23.60(1) An employer who fails to file or make sufficient a report of wages paid to each of its employees for any period in the time and manner set forth in Iowa Code section 96.7 and rule 871—22.3(96) shall pay to the department a penalty in accordance with Iowa Code section 96.14(2).

23.60(2) The amount of the penalty for a delinquent or insufficient report shall be based on the total wages paid by the employer in the period for which the report was due, except that the penalty shall not be less than $35 for the delinquent report or the insufficient report not made sufficient within 30 days of a request to do so. An insufficient report is defined as a quarterly report that does not have all social security numbers, all corresponding names, total wages for each employee, or a reporting unit number. Reports submitted without a correct account number, federal employer identification number, labor market information, signature, or report submitted for an unemployment account that has not yet been established by the employer or agent may be considered insufficient.

23.60(3) Interest and penalty shall not accrue with respect to contributions required from an employer based upon wages for employment in those cases in which the employer's liability is based solely upon the provisions of Iowa Code section 96.19(16)*"g"* until 30 days after determination of such liability under the federal Unemployment Tax Act.

23.60(4) Interest and penalty shall not accrue in those cases where the department finds that, as a matter of equity and good conscience, the employer should not be required to pay interest.

23.60(5) Interest as provided under Iowa Code section 96.14 shall accrue 30 days after the quarterly billing to reimbursable employers.

23.60(6) The penalties applicable to contributory employers shall be applicable to employers who have been approved to make payments in lieu of contributions.

23.60(7) Payment checks not honored by bank. An employer is liable for interest for a check in payment of contributions which is not honored by the bank upon which it is drawn.

This rule is intended to implement Iowa Code section 96.14(2).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.61(96) Collection of interest and penalties. When a report is filed with contributions paid but penalties and interest due, penalties and interest may be assessed and a lien filed in the same manner as for unpaid contributions.

871—23.62(96) Rescission of interest and penalty.

23.62(1) Interest and penalty charges may be rescinded whenever an employer can provide documentary evidence to the satisfaction of the department that an inquiry in writing was directed to the department within 15 days following the end of the quarter for the report(s) or contribution(s) untimely filed or paid, and such contributions are paid in full.

23.62(2) Penalty charges only may be rescinded whenever the employer can show documentary evidence that the wages paid to employees used to determine liability to the department were reported to another state in good faith and the contributions thereon were properly paid to the state to which the wages were reported and that said employees were fully insured during the period of unreported liability to this department.

871—23.63(96) Cancellation of interest and penalty. The department may, at its discretion and for good cause, cancel interest and penalty upon written request for the waiver from the employer or an agent for the employer. Requests should be directed to the department at its administrative office. The employer will be advised if the request is denied.

In determining whether good cause has been shown, the department shall consider all relevant factors including but not limited to whether the party acted in the manner that a reasonably prudent individual would have acted under the same or similar circumstances, whether the party received timely notice of the need to act, whether there was administrative error by the department, whether there were factors outside the control of the party which prevented a timely action, the efforts made by the party to seek an extension of time by promptly notifying the department, the party's physical inability to take timely action, the length of time the action was untimely, and whether any other interested party has been prejudiced by the untimely action.

This rule is intended to implement Iowa Code section 96.14(2).

871—23.64(96) Refund of interest and penalty.

23.64(1) Interest or penalty may be refunded only when it has been erroneously paid or overpaid. Interest or penalty erroneously collected in excess of the amount due may be credited or refunded to the employing unit or other person(s) who paid such interest or penalty subject to the following limitations.

a. If the department determines that a claim for refund or credit is allowable in accordance with the Iowa Code and these rules, it shall so find and make an adjustment as follows:

b. The amount of the overpayment shall first be applied against any unpaid liability then due from or accrued against the employing unit. The remainder of such portion of the overpayment shall be refunded to the employing unit or other person(s) by whom it was paid, or its or their successor, administrators or executors.

23.64(2) Reserved.

871—23.65(96) Liens for unpaid contributions, interest, and penalties.

23.65(1) Filing of liens and notice of jeopardy assessments.

a. If reports are filed by an employer for the purpose of determining the amount of contribution due, or an assessment of contribution due, and the employer fails to pay any part of the contributions, interest and penalties due as determined by the report or assessment, Form 68-0043, Notice of Assessment and Lien, will be sent to the employer.

b. If, 30 days after a Notice of Assessment and Lien, or a Notice of Jeopardy Assessment has been served (see subrule 23.59(2)) and the employer has failed to make payment in full of the amounts that were assessed, the department may file a lien with the county recorder of the county in which the employer has its principal place of business, or with the county recorder of any county in which the employer has real or personal property.

c. The lien, known as a Form 68-0024, Notice of Lien, shall state the date of assessment, the employer's name, address and account number, and the amount due. The recorder shall record the Notice of Lien as provided in Iowa Code section 96.14(3).

23.65(2) When the Notice of Lien is duly filed and recorded, the amount stated shall be a lien upon the entire interest of the employer, legal or equitable, in any real property, and upon any personal property, tangible or intangible, located in any county where the Notice of Lien or copy is filed.

23.65(3) As provided in Iowa Code section 96.14(3), the lien shall attach as of the date the assessment is mailed or personally served upon the employer.

23.65(4) The transfer, through sale, exchange, or other method, of a major portion of the assets of a delinquent employer shall not defeat or impair the lien in favor of the department, and the person acquiring such assets shall be held liable for payment of all delinquent contributions, interest, and penalties due from the delinquent employer. The department shall be made a party to any foreclosure action involving any real or personal property against which the department has or may claim a lien.

23.65(5) Liens against out-of-state employers and resident employers who remove themselves from the state of Iowa may be obtained in accordance with section 96.14(6).

23.65(6) The department may, at its discretion and in accordance with Iowa Code section 96.14(3), make an assessment and file a lien in the recorder's office in the county or state where the employer resides. Liens shall be recorded in accordance with the law governing liens in the state where filed, and the costs shall be borne by the employer.

23.65(7) No employment security lien(s) shall be released without payment of the contributions secured except as follows:

a. It is shown to the department's satisfaction that the lien(s) was filed in error. If this is shown, the lien shall be at the expense of the department.

b. Release of the lien(s) is ordered by a judge having jurisdiction over same.

c. A release is necessary to facilitate payment to the department from proceeds of sale in an equity action.

d. A foreclosure action has been initiated by a secured creditor and it is demonstrated to the department's satisfaction all of the following:

(1) The lien of the secured creditor is properly perfected and is senior to the employment security lien.

(2) The property, both real and personal, does not exceed in value the amount of the secured lien on which the foreclosure is taken.

23.65(8) In such cases, the department may release its lien(s) but such release shall be only in respect to the property foreclosed upon by the secured creditor.

23.65(9) Interest and penalty secured by a lien may be compromised by the department at its discretion.

23.65(10) Upon payment of contributions, interest, penalty, and costs, the department shall execute a Form 68-0199, Satisfaction of Lien, by filing it with the recorder's office for the county where the lien was filed. A copy of this satisfaction shall be mailed to the employer.

This rule is intended to implement Iowa Code section 96.14(3).

871—23.66(96) Jeopardy assessments.

23.66(1) If the department believes the collection of any contribution will be jeopardized by delay, the department may, whether or not the time otherwise prescribed by rule 23.8(96) for making return and paying any contribution has expired, immediately assess the contributions, together with all interest and penalty. The contributions, penalty and interest shall become immediately due and payable. The jeopardy assessment may be made by personal service upon the employer or the employer's agent by a

representative of the department or civil officer of the state. Should immediate personal service not be possible, the jeopardy assessment shall be sent by certified mail to the employer's address of record and such mailing shall be a satisfactory service.

23.66(2) If, after a jeopardy assessment has been served, the amount assessed remains unpaid and no appeal has been filed by the employer, a notice of lien shall be recorded in the recorder's office for the county or counties in which the employer resides or owns property. A copy of the lien shall be mailed to the employer at the address of record.

23.66(3) If, at the time of service of a jeopardy assessment, the employer protests or disputes the correctness of the assessment, the employer may furnish to the department and the department may accept a bond in an amount the department deems necessary but not to exceed double the amount of contributions due, provided the department is satisfied as to the security of the bond. So long as the bond remains in force and the assessment remains in dispute, the department shall not issue a distress warrant. If, after final adjudication of the jeopardy assessment, the employer fails to pay the assessed amount in full, the bond shall be forfeited to the extent necessary to satisfy the jeopardy assessment plus any accrued interest. Any overage shall be refunded to the employer by warrant or credit. If the bond is insufficient to pay the jeopardy assessment in full, the department may issue a distress warrant as provided in rule 23.67(96).

23.66(4) After a lien has been filed and the amount or any portion of the amount assessed and any additional accrued interest remains unpaid, the department may at any time issue a distress warrant instructing a sheriff or peace officer to levy upon and seize or attach any real or personal property of the employer in satisfaction of the amount assessed and secured by the lien.

This rule is intended to implement Iowa Code section 96.7(7).

871—23.67(96) Distress warrants.

23.67(1) In addition to and as an alternative to any other remedy provided by the Iowa Code and these rules, the department may proceed to enforce its lien by issuing to the sheriff of any county or to any civil officer of the state of Iowa having proper jurisdiction a distress warrant commanding the sheriff or civil officer to levy upon and sell any real or personal property which may be found within its jurisdiction belonging to an employer who has defaulted in the payment of any sum determined by the department to be due from the employer, and to pay the proceeds of the sale over to the clerk of district court in and for the county in which the property is found. All costs of the execution shall be charged to the employer.

23.67(2) The sale shall be held after the property has been levied upon, the period of redemption has expired, and the department has petitioned for and been granted a condemnation order in the district court in and for the county in which the property was levied upon, in accordance with the Iowa Code and the Iowa Rules of Civil Procedure.

23.67(3) No property belonging to the employer shall be exempt from execution.

23.67(4) Whenever a warrant is returned not satisfied in full, the department may proceed to issue a new warrant in the amount remaining unsatisfied, together with any additional interest, penalties, and costs, as provided above.

871—23.68 Reserved.

871—23.69(96) Injunction for nonpayment or failure to report.

23.69(1) In addition or as an alternative to any other remedy provided in Iowa Code chapter 96 and this rule, the department may proceed to enjoin an employer who has refused or failed to pay any contributions, interest, or penalty or who has failed to file any reports required by the department.

23.69(2) Discretion as to whether or not to seek an injunction rests with the department.

23.69(3) When the department determines that an injunction should be obtained, the department will send by certified mail or by personal service to the employer at the last-known address for the employer a notice which shall provide the following information:

a. That the department plans to seek an injunction against the employer.

b. The period(s) for which there are delinquent contributions, interest, and penalty due or for which returns have not been filed.

c. The amount of indebtedness.

d. That the injunction will enjoin the employer from operating any businesses in the state of Iowa until one of the following conditions is met:

(1) The entire indebtedness is paid.

(2) The employer files a full and sufficient bond.

(3) The employer has entered into a court-approved plan providing for payment of the indebtedness.

e. The employer has ten days in which to respond to the department.

23.69(4) Upon expiration of the ten days following the notice, if the employer has not responded satisfactorily, the department shall file with the district court for the county in which the employer resides a petition requesting a hearing and an order granting the injunction.

23.69(5) Upon the issuance of a court order granting the injunction, the department shall proceed to periodically check to ensure that the employer is complying with the injunction order. Should the department find that the employer is not in compliance, it will ask the court for a finding of contempt and will ask the court to impose appropriate punishment.

23.69(6) Upon payment in full of the delinquent contributions, interest, and penalty, and the filing of all delinquent reports, the department shall have the injunction dissolved.

23.69(7) If the employer, as the result of a court-approved payment plan, is relieved by the court of the injunction and the employer fails to perform strictly as set out in the plan, the department may, at its discretion, ask the court to reinstate the injunction upon notice and hearing.

23.69(8) Any costs of these actions shall be borne by the employer.

871—23.70(96) Nonprofit organizations.

23.70(1) Any nonprofit organization can be considered eligible to reimburse the Iowa unemployment compensation fund in lieu of paying contributions. Any nonprofit organization wishing to be considered as a reimbursable employer shall file as provided under Iowa Code section 96.7 the election to reimburse the fund on Form 68-0463, Election to Make Payments in Lieu of Contributions, with the department for its consideration.

23.70(2) Election to Make Payments in Lieu of Contributions, Form 68-0463, must be signed by an authorized official of the nonprofit organization and shall be accompanied by:

a. A letter of intent indicating the organization's desire to be considered for reimbursable status.

b. A copy of the organization's letter of 501(c)(3) exemption from the Internal Revenue Service. If the organization does not have a 501(c)(3) letter at the time of the filing of its election to become a reimbursable employer, it may file a written request with the department for an extension of time setting forth the reason for the request, and the department may grant such extension not to exceed 180 days. Included with this request for extension of time should be a copy of the application for exemption, Election to Make Payments in Lieu of Contributions, or evidence that the request for 501(c)(3) exemption has been made.

c. A corporate charter or other documents that brought the organization into being.

23.70(3) All requests by nonprofit organizations wishing to be considered for reimbursable status shall be filed on Form 68-0463 and that form, along with the organization's 501(c)(3) Internal Revenue Service letter of exemption, except as otherwise provided in subrule 23.70(2), shall be directed to the attention of the field audit unit. The request for reimbursable status will be examined by a field auditor or other authorized representative.

23.70(4) and **23.70(5)** Rescinded IAB 2/10/99, effective 3/17/99.

23.70(6) An organization not possessing a 501(c)(3) nonprofit tax exemption at the time its election is submitted shall be granted reimbursable status provided that the exemption is obtained and a copy is filed with the department within 180 days of the date the election is submitted. Should the organization fail to obtain an exemption within 180 days, the election shall be invalid and the organization shall be required to pay contributions upon all taxable wages paid during the period covered by the invalid election at the contribution rate it would have had if the invalid election had not been made. A new

election may not be made by the organization until it has obtained a 501(c)(3) nonprofit tax exemption and has filed a new election. The new election shall not be retroactive to cover the period of the invalid election. Benefits reimbursed during the invalid election shall be used to offset the contributions due, and any excess shall be refunded to the organization.

23.70(7) to **23.70(9)** Rescinded IAB 2/10/99, effective 3/17/99.

23.70(10) The department may for good cause extend the period within which a notice of election to become a reimbursable employer or a notice to terminate reimbursable status must be filed and permit an election to be retroactive.

23.70(11) Any nonprofit organization that terminates its election to reimburse the fund shall continue to be liable to reimburse the fund for benefits which are paid based on wages earned during the effective period of the employer's Election to Make Payments in Lieu of Contributions. All benefits charges based on wages paid after the date of the approval of the change of status to a contributory employer shall be charged to the employer's contributory account.

a. A nonprofit organization changing its tax status from reimbursable to contributory or contributory to reimbursable will retain the same employer account number. A nonprofit organization terminating its election to reimburse the fund shall be treated as a newly covered employer for the purpose of establishing a contribution rate, except as provided in paragraph *"b."*

b. The experience, while under each tax status, will not be combined for rate computation purposes unless the department finds, or has reason to believe, that the nonprofit organization changing from a reimbursable status to a contributory status is unable to reimburse the fund for benefits outstanding at the time of the change in status, plus any benefits paid after the change in status that are based on wages paid while the nonprofit organization was still in a reimbursable status. The department may then, at its own option, use the unreimbursed benefits in the computation of the nonprofit organization's contribution rate and transfer any contributions collected, above what the nonprofit organization would have paid as a newly covered employer, from the nonprofit organization's contributory account to the reimbursable account to apply against the unreimbursed benefits.

23.70(12) Any nonprofit organization which elects to change its status from contributory to reimbursable shall continue to be liable for charges on all benefits based on wages paid when the nonprofit organization was a contributory employer. These charges will be charged to the nonprofit organization's contributory account. The experience of the contributory account will not be merged with the nonprofit organization's reimbursable account.

23.70(13) In the event that a reimbursable nonprofit organization succeeds to a contributory employer, such successor employer shall not receive a transfer of account balance from the predecessor account. The account balance shall remain with the predecessor account and be used as an offset against any claims attributable to that account. If an employer, whether or not the employer may elect to be reimbursable, becomes a successor to a reimbursable nonprofit organization, the successor employer shall become obligated for the reimbursable nonprofit organization's unpaid benefit charges in the event that the reimbursable nonprofit organization cannot meet this obligation. The successor employer shall also be liable to reimburse the department, whether or not the successor employer is reimbursable or is eligible to elect to become reimbursable, for benefits paid after the date of the sale or transfer that are based on wages paid by the reimbursable nonprofit organization prior to the date of the sale or transfer.

23.70(14) In the event a reimbursable nonprofit organization discontinues business, the reimbursable nonprofit organization will continue to be liable to reimburse the fund in an amount equivalent to the amount of regular unemployment benefits and one-half of the extended benefits paid to an individual that is attributable to wages paid by the reimbursable nonprofit organization prior to the discontinuance of business.

This rule is intended to implement Iowa Code section 96.7(9).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—23.71(96) Governmental entity—definition.

23.71(1) The definition of a governmental entity is a state, a state instrumentality, a political subdivision or a political subdivision instrumentality, or a combination of one or more of the preceding.

An instrumentality of one or more states or political subdivisions may be a part of a state or a political subdivision or it may be independent of political entities and thereby a separate governmental entity. The definition of a governmental entity is held to include but not be limited to:

a. An organization or any division, department, agency, commission, or board of a state or political subdivision established by proper authorities, authorized and created under constitutional provisions or statutes, for the purpose of carrying out a portion of the function of government, including both governmental and proprietary functions.

b. An instrumentality is one which is organized to carry on some function or purpose of government for a state or a political subdivision. There is expressed or implied statutory or other authority creating it. It is an independent legal entity, with power to hire, supervise, and discharge its own employees. Generally, it can sue or be sued in its own name, to hold, convey real and personal property and borrow money.

c. Political subdivisions include counties, cities, municipalities, towns, villages, townships, as well as irrigation, flood control, sanitation, utility, reclamation, drainage, improvement, and public school districts and authorities or any combination of these and similar governmental entities within the state of Iowa.

d. Instrumentalities shall include departments, boards, agencies, commissions, county or municipal corporations, associations and organizations of a state or a political subdivision of the state when it is operated by virtue of the authority, power, or powers conferred upon it by a state or political subdivision of the state, or when they are controlled, supervised or receive direction, expressed or implied, from a state or political subdivision of a state or such rights are vested in public authority or authorities, or the state or the political subdivision of a state has the right, expressed or implied, to control or direct the policy, operation or to influence the organizations or action of individuals, parties or interests that control those who manage or administer the affairs of such organizations.

23.71(2) In cases involving the status of an organization as to whether it is a state, a state instrumentality, a political subdivision of a state or a political subdivision instrumentality, the following factors may be taken into account:

a. Whether the revenues are subject to control by a state, a political subdivision of a state or an instrumentality of either.

b. They may have broad powers of taxation, appropriation or authority to levy special assessments on the land located in the district which will stand as a lien upon the property assessed.

c. It is created or existing by virtue of a state, a political subdivision of the state or instrumentality of either, which operates in the public interest, without profit to private persons, and whose purpose is presumed to be a public benefit and conducive to the public health, convenience and welfare.

d. Whether it is organized or used for a governmental purpose, or an aid in the function of government or it performs a governmental function.

e. Whether there is an expressed or implied statutory or other authority necessary or existing for the creation or use of the organization.

23.71(3) The term "employment" does not apply to services performed for this state, a political subdivision of this state, an Indian tribe or an instrumentality of either by an individual who is: an elected official; a member of a legislative body; a member of the judiciary of a state or political subdivision; a member of the state national guard, air national guard, or armed forces reserve; an employee on a temporary-duty basis in the case of fire, storm, snow, earthquake, flood or similar emergency; or in a position designated as a major nontenured policymaking or advisory position pursuant to state law if the position does not ordinarily require duties of more than eight hours per week.

a. The exclusion for a governmental entity or Indian tribe from coverage of unemployment of the services of an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or similar emergency applies only to those individuals who are hired or pressed into service to assist directly with an emergency or urgent distress associated with an emergency, including such temporary tasks as firefighting, rescue, removal of storm debris, cleaning up mud and flood debris, restoration of public facilities, snow removal and road clearance. Volunteer firefighters and police officers, and snow removal personnel, who are called to duty in emergency situations such as fires, floods, emergency snow

removal or similar public emergency to perform services on a temporary basis for which they receive pay, are excluded from coverage. *City of Charles City v. Iowa Department of Job Service*, Law No. 2262, District Court for Floyd County. The exclusion does not apply to permanent employees whose usual responsibilities include emergency situations.

b. The provision which excludes an individual employed by a governmental entity or Indian tribe who exercises duties in a position defined in state law as a major nontenured policymaking or advisory position, or a policymaking or advisory position which ordinarily does not require duties of more than eight hours per week, covers those individuals holding positions designated by, or pursuant to, state law as a policymaking or advisory position. Political subdivisions which have authority to enact ordinances or resolutions without recourse to the state legislature but under authority of state law may also establish and define such positions. The positions may qualify for the exclusion if the political subdivision has enacted an ordinance or resolution creating or designating one of its positions as policymaking or advisory, provided power to make the ordinance or resolution is authorized or permitted by the laws of the state. If the state law or local ordinance or resolution properly designated the positions as policymaking or advisory, the exclusion is clearly applicable. Where the law or the ordinance does not clearly and specifically so categorize or label the position, other pertinent factors such as job descriptions, the qualification of individuals considered for and appointed to the position and the responsibilities involved shall be taken into account in determining the character of the position for purposes of applying the exclusion.

(1) "Policymaker" is defined as generally referring to the determination of the direction, emphasis and scope of action in the development of, and the administration of, governmental programs. Such responsibilities are confined to and inherent in jobs of the higher echelons of government.

(2) An "advisory position" is one which advises established governmental agencies and officers with respect to policy, program and administration without having authority to implement the recommendations.

(3) The word "major" in the phrase "major nontenured policymaking or advisory position" refers to high level governmental positions usually filled by appointment by the chief executive of the political entity (governor, mayor, etc.), or a council, and which involves responsibilities affecting the entire political entity, whether it be the state, county or city.

(4) The term "nontenured" is used in its usual meaning to mean that the position is not covered by merit system or civil service law or rules with respect to duration of appointment to the service.

(5) Service in a policymaking or advisory position where the performance of the duties ordinarily does not require more than eight hours per week is exempted. It makes no difference whether the position is tenured or not. If the position ordinarily requires more than eight hours per week, the exclusion does not apply. The number of hours required should be determined by reference to the law establishing the position and the actual time spent by incumbents.

c. An elected official includes an individual appointed to serve the unexpired term of an elected position. Such an individual's services for such period are excluded because the individual is performing excluded services.

d. An official elected by a body other than the public, such as by a vote by the legislature, board of supervisors, council, school board or trustees, to perform services for a government entity, such individual is not excluded from coverage.

e. Services performed for the state national guard or the air national guard are excluded from coverage of the employment security law only as to the services in the individual's "military" capacity. It does not apply to any service performed in any other capacity.

f. If a member of the state national guard or air national guard is employed in a civilian capacity performing services for either organization as distinguished from "military" service, the civilian service would be covered as an employee of a governmental entity to the same extent as any other employee.

23.71(4) Exemption from "employment" for individuals performing services for a governmental entity or Indian tribe as part of an unemployment work relief or work training program. Services performed by an individual for a government entity or Indian tribe for the purpose of qualifying or repaying a welfare or relief grant will not be considered "employment" provided that:

a. The major purpose of the program under which the work is performed is to relieve individuals from their unemployment or poverty.

b. The government entity does not pay the welfare or relief grant directly to the individual but instead pays items such as rent, power bills, medical bills, etc., for the individual.

c. The services performed by the individuals do not displace regularly employed workers of the government entity.

This rule is intended to implement Iowa Code sections 96.7(8) and 96.19(18)*"a"*(6)(e) and (g).

871—23.72(96) Governmental entity—elective coverage and liability.

23.72(1) Any governmental entity may elect to be a governmental contributory employer by filing a written application known as "Election to Pay Contributions as a Government Contributory Employer," Form 68-0053, for elective coverage as a governmental contributory employer. The rules governing the selection of coverage status for governmental entities shall apply to Indian tribes. Any governmental entity failing to file such an election will be considered as a governmental reimbursable employer. The Form 68-0053 must be signed by a duly constituted governmental official. The election shall be approved if the department finds that:

a. It is an application for all employees of the entity.

b. The applicant is a "governmental entity."

c. It sets forth the name and address of the entity.

23.72(2) The effective date of an elective coverage agreement filed by a government entity is the first day of the calendar year in which the election was filed.

23.72(3) An agreement for elective coverage shall be continued in effect from period to period unless a written application for termination has been filed with the department 30 days before the beginning of the taxable year for which such termination shall first be effective following the initial one-year period of coverage.

23.72(4) An applicant may withdraw an application for elective coverage prior to final approval of the application. The department may, upon written request of the applicant, cancel an elective coverage agreement which has been finally approved if the applicant shows that the application was submitted through justifiable mistake, or error, or was submitted by a person not having proper authorization to bind the applicant.

23.72(5) If a governmental entity is succeeded in whole or in part by another governmental entity, the successor may elect to continue the elective coverage agreement of the predecessor or may elect to terminate the elective coverage agreement of the predecessor. If the successor governmental entity was, prior to the acquisition of the predecessor, a governmental entity under an approved elective coverage agreement, the elective coverage agreement of the predecessor shall be continued to the same extent as the elective coverage agreement of the successor. If the successor governmental entity was, prior to the acquisition of the predecessor, a governmental entity not under an approved elective coverage agreement, the successor shall meet the requirements of this section if it elects to continue the elective coverage agreement of the predecessor.

23.72(6) The contribution rate of a governmental contributory employer shall be determined by the ranking of the governmental contributory employer's percentage of excess when compared to all other governmental contributory employers' percentage of excesses and the rate assigned to each rank as determined by the base rate of all governmental contributory employers. The base rate is determined by adding or subtracting the difference between the benefits charged and the contributions paid by governmental contributory employers since January 1, 1980 (adjusted if necessary by excess contributions from calendar years 1978 and 1979), to or from the total benefits charged to governmental contributory employers during the preceding calendar year and dividing this sum by the total taxable wages reported by governmental contributory employers during the same calendar year. The contribution rate of a governmental contributory employer shall be payable on the taxable wages paid by the governmental contributory employer.

23.72(7) Liability upon the sale, transfer or discontinuance of a reimbursable governmental employer.

a. If a governmental reimbursable employer sells or otherwise transfers its enterprise, business, or operation to a subsequent employing unit, and the subsequent employing unit is determined to be a successor employer, the successor employer shall become liable to the department for the predecessor governmental reimbursable employer's benefit charges that are unpaid as of the date of the sale or transfer in the event that the predecessor governmental reimbursable employer cannot meet this obligation. The successor employer shall also be liable to reimburse the department, whether or not the successor employer is reimbursable or is eligible to elect to become reimbursable, for benefits paid after the date of the sale or transfer that are based on wages paid by the predecessor governmental reimbursable employer prior to the date of the sale or transfer.

b. If a reimbursable instrumentality of either a state or a political subdivision is discontinued other than by sale or transfer, the state or the political subdivision shall reimburse the department for the reimbursable instrumentality's benefit charges that are unpaid at the time the reimbursable instrumentality was discontinued. In addition, the state or the political subdivision shall be liable to reimburse the department for benefits paid after the discontinuance of the reimbursable instrumentality that are based on wages paid by the reimbursable instrumentality prior to the discontinuance.

This rule is intended to implement Iowa Code section 96.7(8).

871—23.73(96) Governmental entities—delinquent accounts.

23.73(1) Any governmental entity which is an employer and which becomes delinquent in the payment of contributions or the reimbursement of benefits shall be assessed for the same together with any interest and penalty due thereon.

23.73(2) Contributions are due within 30 days of the end of the quarter for which they are incurred. Reimbursable benefit payments are due 30 days after the date of the statement.

23.73(3) If an amount due from a governmental entity of this state remains due and unpaid for a period of 120 days after the due date, the department shall take action as necessary to collect the amount and shall levy against any funds due the governmental entity from the state treasurer, director of the department of revenue, or any other official or agency of this state or against an account established by the entity in any bank. The official, agency or bank shall deduct the amount certified by the department from any accounts or deposits or any funds due the delinquent governmental entity without regard to any prior claim and shall promptly forward the amount to the department for the fund. However, the department shall notify the delinquent entity of the department's intent to file a levy by certified mail at least ten days prior to filing the levy on any funds due the entity from any state official or agency.

This paragraph is an exact quote from 1979 Iowa Acts, chapter 33, section 25. It is being used as a rule because it conflicts with the preceding paragraph in Iowa Code chapter 96. The preceding paragraph in section 96.14(3) states delinquency as a period exceeding two calendar quarters. The above period of 120 days is the most recent expression of the legislature.

This rule is intended to implement Iowa Code section 96.14(3) and 1979 Iowa Acts, chapter 33.

871—23.74 to **23.81** Reserved.

871—23.82(96) Definition of construction employer.

23.82(1) Construction. The department will utilize the North America Industry Classification System manual (2002 edition) to determine which employers will be classified as construction. The manual may be purchased through Bernan Press, 4611F Assembly Drive, Landham, MD 20706-4391, and is available on the Internet at http://www.ntis.gov/naics.

a. The construction sector is comprised of establishments primarily engaged in the construction of buildings and other structures, heavy construction (except buildings), additions, alterations, reconstruction, installation, and maintenance and repairs. Establishments engaged in demolition or wrecking of buildings and other structures, clearing of building sites, and sale of materials from demolished structures are also included. This sector also includes those establishments engaged in blasting, test drilling, landfill, leveling, earthmoving, excavating, land drainage, and other land preparation. The industries within this sector have been defined on the basis of their unique production

processes. As with all industries, the production processes are distinguished by their use of specialized human resources and specialized physical capital. Construction activities are generally administered or managed at a relatively fixed place of business, but the actual construction work is performed at one or more different project sites. Employers that provide workers primarily for construction will be classified as construction employers.

b. This sector is divided into three subsectors of construction activities: (1) building construction and land subdivision and land development; (2) heavy construction (except buildings), such as highways, power plants, and pipelines; and (3) construction activity by special trade contractors.

c. Establishments classified in Subsector 233, Building, Developing, and General Contracting, and Subsector 234, Heavy Construction, usually assume responsibility for an entire construction project, and may subcontract some or all of the actual construction work. Operative builders who build on their own account for sale and land subdividers and land developers, who engage in subdividing real property into lots for sale, are included in Subsector 233, Building, Developing, and General Contracting. (Special trade contractors are included in Subsector 234, Heavy Construction, if they are engaged in activities primarily relating to heavy construction, such as grading for highways.) Establishments included in these subsectors operate as general contractors, design-builders, engineer-constructors, joint-venture contractors, and turnkey construction contractors. Establishments identified as construction management firms are also included.

d. Establishments classified in Subsector 235, Special Trade Contractors, are primarily engaged in specialized construction activities, such as plumbing, painting, and electrical work, and work for builders and general contractors under subcontract or directly for project owners. Establishments engaged in demolition or wrecking of buildings and other structures, dismantling of machinery, excavating, shoring and underpinning, anchored earth retention activities, foundation drilling, and grading for buildings are also included in this subsector.

e. "Force account" construction is construction work performed by an establishment primarily engaged in some business other than construction, for its own account and use, and by employees of the establishment. This activity is not included in this industry sector unless the construction work performed is the primary activity of a separate establishment of the enterprise.

f. The installation of prefabricated building equipment and materials, such as elevators and revolving doors, is classified in the construction sector. Installation work incidental to sales by employees of a manufacturing or retail establishment is classified as an activity of those establishments.

23.82(2) The term "construction" includes, but is not limited to:

a. Land subdividing and land development. Establishments primarily engaged in subdividing real property into lots or developing lots for sale.

b. Residential building construction.

(1) Single-family housing construction. Establishments primarily responsible for the entire construction (i.e., new work, additions, alterations, and repairs) of single-family residential housing units.

Building alterations, single-family—general contractors
Building construction, single-family—general contractors
Custom builders, single-family houses—general contractors
Designing and erecting, combined: single-family houses—general contractors
Home improvements, single-family—general contractors
House construction, single-family—general contractors
House: shell erection, single-family—general contractors
Mobile home repair, on site—general contractors
Modular housing, single-family (assembled on site)—general contractors
One-family house construction—general contractors
Prefabricated single-family houses erection—general contractors
Premanufactured housing, single-family (assembled on site)—general contractors
Remodeling buildings, single-family—general contractors
Renovating buildings, single-family—general contractors

Repairing buildings, single-family—general contractors
Residential construction, single-family—general contractors
Row house (single-family) construction—general contractors
Town house construction—general contractors

(2) Multifamily housing construction. Establishments primarily responsible for the entire construction (i.e., new work, additions, alterations and repairs) of multifamily residential housing units.

Apartment building construction—general contractors
Building alterations, residential: except single-family—general contractors
Building construction, residential: except single-family—general contractors
Custom builders, residential: except single-family—general contractors
Designing and erecting, combined: residential, except single-family—general contractors
Dormitory construction—general contractors
Home improvements, residential: except single-family—general contractors
Prefabricated building erection, residential: except single-family—general contractors
Remodeling buildings, residential: except single-family—general contractors
Renovating buildings, residential: except single-family—general contractors
Repairing buildings, residential: except single-family—general contractors
Residential construction, except single-family—general contractors

c. Nonresidential building construction.

(1) Manufacturing and industrial building construction. Establishments primarily responsible for the entire construction (i.e., new work, additions, alterations and repairs) of manufacturing and industrial buildings.

Building alterations, industrial and warehouse—general contractors
Building components manufacturing plant construction—general contractors
Building construction, industrial and warehouse—general contractors
Clean room construction—general contractors
Cold storage plant construction—general contractors
Commercial warehouse construction—general contractors
Custom builders, industrial and warehouse—general contractors
Designing and erecting, combined: industrial—general contractors
Dry cleaning plant construction—general contractors
Factory construction—general contractors
Food products manufacturing or packing plant construction—general contractors
Grain elevator construction—general contractors
Industrial building construction—general contractors
Industrial plant construction—general contractors
Paper pulp mill construction—general contractors
Pharmaceutical manufacturing plant construction—general contractors
Prefabricated building erection, industrial—general contractors
Remodeling buildings, industrial and warehouse—general contractors
Renovating buildings, industrial and warehouse—general contractors
Repairing buildings, industrial and warehouse—general contractors
Truck and automobile assembly plant construction—general contractors
Warehouse construction—general contractors

(2) Commercial and industrial building construction. Establishments primarily responsible for the entire construction (i.e., new work, additions, alterations and repairs) of commercial and industrial buildings.

Administration building construction—general contractors
Amusement building construction—general contractors
Auditorium construction—general contractors
Bank building construction—general contractors
Building alterations, nonresidential: except industrial and warehouses—general contractors

Building construction, nonresidential: except industrial and warehouses—general contractors
Casino construction—general contractors
Church, synagogue and related building construction—general contractors
Civic center construction—general contractors
Commercial building construction—general contractors
Custom builders, nonresidential: except industrial and warehouses—general contractors
Designing and erecting, combined: commercial—general contractors
Dome construction—general contractors
Farm building construction, except residential—general contractors
Fire station construction—general contractors
Garage construction—general contractors
Hospital construction—general contractors
Hotel construction—general contractors
Institutional building construction, nonresidential—general contractors
Mausoleum construction—general contractors
Motel construction—general contractors
Municipal building construction—general contractors
Museum construction—general contractors
Office building construction—general contractors
Passenger and freight terminal building construction—general contractors
Post office construction—general contractors
Prefabricated building erection, nonresidential: except industrial and warehouses—general contractors
Prison construction—general contractors
Remodeling buildings, nonresidential: except industrial and warehouses—general contractors
Renovating buildings, nonresidential: except industrial and warehouses—general contractors
Repairing buildings, nonresidential: except industrial and warehouses—general contractors
Restaurant construction—general contractors
School building construction—general contractors
Service station construction—general contractors
Shopping center construction—general contractors
Silo construction, agricultural—general contractors
Stadium construction—general contractors
Store construction—general contractors

d. Highway, street, bridge and tunnel construction.

(1) Highway and street construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction, or repairs) of highways (except elevated), streets, roads, or airport runways, and establishments identified as highway and street construction management firms, and establishments identified as special trade contractors engaged in performing subcontract work primarily related to highway and street construction.

Airport runway construction—general contractors
Alley construction—general contractors
Asphalt paving; roads, public sidewalks and streets—contractors
Concrete construction; roads, highways, public sidewalks, and streets—contractors
Grading for highways, streets and airport runways—contractors
Guardrail construction on highways—contractors
Highway construction, except elevated—general contractors
Highway signs, installation of—contractors
Parkway construction—general contractors
Paving construction—contractors
Resurfacing streets and highways—contractors
Road construction, except elevated—general contractors

Sidewalk construction, public—contractors
Street maintenance or repair—contractors
Street paving—contractors

(2) Bridge and tunnel construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction, or repairs) of bridges, viaducts, elevated highways and tunnels, and establishments identified as bridge and tunnel construction management firms, and establishments identified as special trade contractors primarily engaged in performing subcontract work related to bridge and tunnel construction.

Abutment construction—general contractors
Bridge construction—general contractors
Causeway construction on structural supports—general contractors
Highway construction, elevated—general contractors
Overpass construction—general contractors
Trestle construction—general contractors
Tunnel construction—general contractors
Underpass construction—general contractors
Viaduct construction—general contractors

e. Other heavy construction.

(1) Water, sewer, and pipeline construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction, rehabilitation or repairs) of water mains, sewers, drains, gas mains, natural gas pumping stations, and gas and oil pipelines, and establishments identified as water, sewer and pipeline construction management firms, and establishments identified as special trade contractors engaged in activities primarily related to water, sewer, and pipeline construction.

Aqueduct construction—general contractors
Conduit construction—contractors
Distribution lines (oil and gas field) construction—general contractors
Gas main construction—general contractors
Manhole construction—contractors
Natural gas compressing station construction—general contractors
Pipe laying—general contractors
Pipeline construction—general contractors
Pipeline wrapping—contractors
Pumping station construction—general contractors
Sewage collection and disposal line construction—general contractors
Sewer construction—general contractors
Water main line construction—general contractors

(2) Power and communication transmission line construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction, rehabilitation or repairs) of electric power and communication transmission lines and towers, radio and television transmitting/receiving towers, cable laying, and cable television lines, and establishments identified as power and communication transmission line construction management firms, and establishments identified as special trade contractors engaged in activities primarily related to power and communication line construction.

Cable laying construction—contractors
Cable television line construction—contractors
Pole line construction—general contractors
Power line construction—general contractors
Telegraph line construction—general contractors
Telephone line construction—general contractors
Television and radio transmitting tower construction—general contractors
Transmission line construction—general contractors

(3) Industrial nonbuilding structure construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction, rehabilitation or repairs) of heavy industrial nonbuilding structures, such as chemical complexes, or facilities, cement plants, petroleum refineries, industrial incinerators, ovens, kilns, power plants (except hydroelectric plants), and nuclear reactor containment structures, and establishments identified as industrial nonbuilding construction management firms, and establishments identified as special trade contractors engaged in activities primarily related to industrial nonbuilding construction.

Chemical complex or facilities construction—general contractors
Coke oven construction—general contractors
Discharging station construction, mine—general contractors
Furnace construction for industrial plants—general contractors
Industrial incinerator construction—general contractors
Industrial plant appurtenance construction—general contractors
Kiln construction—general contractors
Light and power plant construction—general contractors
Loading station construction, mine—general contractors
Mine loading and discharging station construction—general contractors
Mining appurtenance construction—general contractors
Nuclear reactor containment structure construction—general contractors
Oil refinery construction—general contractors
Oven construction, bakers'—general contractors
Oven construction for industrial plants—general contractors
Petrochemical plant construction—general contractors
Petroleum refinery construction—general contractors
Power plant construction—general contractors
Tipple construction—general contractors
Washeries construction, mining—general contractors

(4) All other heavy construction. Establishments primarily responsible for the entire construction (i.e., new work, reconstruction or repairs) of heavy nonbuilding construction projects (except highway, street, bridge, tunnel, water lines, sewer lines, pipelines, and power and communication transmission lines), and industrial nonbuilding structures, and establishments identified as all other heavy construction management firms, and establishments primarily engaged in construction equipment rental with an operator, and establishments identified as special trade contractors engaged in activities primarily related to all other heavy construction.

Athletic field construction—general contractors
Blasting, except building demolition—contractors
Breakwater construction—general contractors
Bridle path construction—general contractors
Brush clearing or cutting—contractors
Caisson drilling—contractors
Canal construction—general contractors
Channel construction—general contractors
Channel cutoff construction—general contractors
Clearing of land—general contractors
Cofferdam construction—general contractors
Cutting right-of-way—general contractors
Dam construction—general contractors
Dike construction—general contractors
Dock construction—general contractors
Drainage project construction—general contractors
Dredging—general contractors
Earthmoving, not connected with building construction—general contractors

Flood control project construction—general contractors
Golf course construction—general contractors
Harbor construction—general contractors
Heavy equipment rental with an operator—contractors
Hydroelectric plant construction—general contractors
Irrigation projects, construction—general contractors
Jetty construction—general contractors
Land clearing—contractors
Land drainage—contractors
Land leveling (irrigation)—contractors
Land reclamation—contractors
Levee construction—general contractors
Lock and waterway construction—general contractors
Marine construction—general contractors
Missile facilities construction—general contractors
Pier construction—general contractors
Pile driving—general contractors
Pond construction—general contractors
Railroad construction—general contractors
Railway roadbed construction—general contractors
Reclamation projects construction—general contractors
Reservoir construction—general contractors
Revetment construction—general contractors
Rock removal-underwater—contractors
Sewage treatment plant construction—general contractors
Ski tow erection—general contractors
Soil compacting service—contractors
Submarine rock-removal—general contractors
Subway construction—general contractors
Tennis court construction, outdoor—general contractors
Timber removal-underwater—contractors
Trail building—general contractors
Trailer camp construction—general contractors
Trenching—contractors
Waste disposal plant construction—general contractors
Water power project construction—general contractors
Water treatment plant construction—general contractors
Waterway construction—general contractors
Wharf construction—general contractors

f. Plumbing, heating and air conditioning contractors. Establishments primarily engaged in one or more of the following: (1) installing plumbing, heating, and air-conditioning equipment; (2) servicing plumbing, heating, and air-conditioning equipment; and (3) the combined activity of selling and installing plumbing, heating, and air-conditioning equipment. The plumbing, heating, and air-conditioning work performed includes new work, additions, alterations, and maintenance and repairs.

Air system balancing and testing—contractors
Air conditioning, with or without sheet metal work—contractors
Boiler cleaning—contractors
Boiler erection and installation—contractors
Drainage system installation (cesspool and septic tank)—contractors
Dry well (cesspool) construction—contractors
Fuel oil burner installation and servicing—contractors

Furnace repair—contractors
Gasline hookup—contractors
Heating equipment installation—contractors
Heating, with or without sheet metal work—contractors
Lawn sprinkler system installation—contractors
Mechanical contractors
Piping, plumbing—contractors
Plumbing and heating—contractors
Plumbing repair—contractors
Plumbing, with or without sheet metal work—contractors
Solar heating apparatus—contractors
Sprinkler system installation—contractors
Steam fitting—contractors
Sump pump installation and servicing—contractors
Ventilating work, with or without sheet metal work—contractors
Water pump installation and servicing—contractors
Water system balancing and testing—contractors
Work combined with heating or air conditioning—contractors

g. Painting and wall covering contractors. Establishments primarily engaged in interior or exterior painting and interior wall covering. The painting and wall covering work includes new work, additions, alterations, and maintenance and repairs.

Bridge painting—contractors
Electrostatic painting on site (including lockers and fixtures)—contractors
House painting—contractors
Painting of buildings and other structures, except roofs—contractors
Paper hanging—contractors
Ship painting—contractors
Traffic lane painting—contractors
Wallpaper removal—contractors
Whitewashing—contractors

h. Electrical contractors. Establishments primarily engaged in one or more of the following: (1) performing electrical work at the site; (2) servicing electrical equipment at the site; and (3) the combined activity of selling and installing electrical equipment. The electrical work performed includes new work, additions, alterations, and maintenance and repairs.

Cable splicing, electrical—contractors
Cable television hookup—contractors
Communication equipment installation—contractors
Electric work—contractors
Electrical repair at site of construction—contractors
Electronic control system installation—contractors
Highway lighting and electrical signal construction—contractors
Intercommunication equipment installation—contractors
Sound equipment installation—contractors
Telecommunications equipment installation—contractors
Telephone and telephone equipment installation—contractors

i. Masonry, stone work, tile setting and plastering.

(1) Masonry and stone contractors. Establishments primarily engaged in masonry work, stone setting, and other stone work. The masonry work, stone setting and other stone work performed includes new work, additions, alterations, and maintenance and repairs.

Bricklaying—contractors
Cement block laying—contractors
Chimney construction and maintenance—contractors

Concrete block laying—contractors
Foundations, building of: block, stone or brick—contractors
Marble work, exterior construction—contractors
Masonry—contractors
Refractory brick construction—contractors
Retaining wall construction: block, stone or brick—contractors
Stone setting—contractors
Stone work erection—contractors
Tuck pointing—contractors

(2) Drywall, plastering, acoustical, and insulation contractors. Establishments primarily engaged in drywall, plaster work, acoustical and building insulation work. The drywall, plaster work, acoustical and insulation work performed includes new work, additions, alterations, and maintenance and repairs.

Acoustical work—contractors
Ceilings, acoustical installation—contractors
Drywall construction—contractors
Insulation installation, buildings—contractors
Lathing—contractors
Plastering, plain or ornamental—contractors
Solar reflecting insulation film—contractors
Stucco construction—contractors
Taping and finishing drywall—contractors

(3) Tile, marble, terrazzo, and mosaic contractors. Establishments primarily engaged in (1) setting and installing ceramic tile, marble (interior only), terrazzo, and mosaic, or (2) mixing marble particles and cement to make terrazzo at the job site. The tile, marble, terrazzo, and mosaic work performed includes new work, additions, alterations, and maintenance and repairs.

Fresco work—contractors
Mantel work—contractors
Marble installation, interior; including finishing—contractors
Mosaic work—contractors
Terrazzo work—contractors
Tile installation, ceramic—contractors
Tile setting, ceramic—contractors

j. Carpentering and floor contractors.

(1) Carpentry contractors. Establishments primarily engaged in framing, carpentry, and finishing work. The carpentry work performed includes new work, additions, alterations, and maintenance and repairs.

Carpentry work—contractors
Folding door installation—contractors
Framing—contractors
Garage door installation—contractors
Joinery, ship—contractors
Ship joinery—contractors
Store fixture installation—contractors
Trim and finish—contractors
Window and door (prefabricated) installation—contractors

(2) Floor laying and other floor contractors. Establishments primarily engaged in the installation of resilient floor tile, carpeting, linoleum, and wood or resilient flooring. The floor laying and other floor work performed includes new work, additions, alterations, and maintenance and repairs.

Asphalt tile installation—contractors
Carpet laying or removal service—contractors
Fireproof flooring construction—contractors
Floor laying, scraping, finishing and refinishing—contractors

Flooring, wood—contractors
Hardwood flooring—contractors
Linoleum installation—contractors
Parquet flooring—contractors
Resilient floor laying—contractors
Vinyl floor tile and sheet installation—contractors

k. Roofing, siding, and sheet metal contractors. Establishments primarily engaged in the installation of roofing, siding, sheet metal work, and roof drainage-related work, such as downspouts and gutters. The roofing, siding and sheet metal work performed includes new work, additions, alterations, and maintenance and repairs.

Architectural sheet metal work—contractors
Ceilings, metal; erection and repair—contractors
Coppersmithing, in connection with construction work—contractors
Downspout installation, metal—contractors
Duct work, sheet metal—contractors
Gutter installation, metal—contractors
Roof spraying, painting or coating—contractors
Roofing work, including repairing—contractors
Sheet metal work: except plumbing, heating or air conditioning—contractors
Siding—contractors
Skylight installation—contractors
Tinsmithing, in connection with construction work—contractors

l. Concrete contractors. Establishments primarily engaged in the use of concrete and asphalt to produce parking areas, building foundations, structures, and retaining walls and the use of all materials to produce patios, private driveways and private walks. The concrete work performed includes new work, additions, alterations, and maintenance and repairs.

Asphalting of private driveways and private parking areas—contractors
Blacktop work; private driveways and private parking areas—contractors
Concrete finishers—contractors
Concrete work: private driveways, sidewalks, and parking areas—contractors
Culvert construction—contractors
Curb construction—contractors
Foundations, building of: poured concrete—contractors
Grouting work—contractors
Gunite work—contractors
Parking lot construction—contractors
Patio construction, concrete—contractors
Sidewalk construction, except public—contractors

m. Water well drilling contractors. Establishments primarily engaged in drilling, tapping, and capping of water wells and geothermal drilling. The water well drilling work performed includes new work, additions, alterations, and maintenance and repairs.

Drilling water wells—contractors
Geothermal drilling—contractors
Servicing water wells—contractors
Well drilling, water: except oil or gas field water intake—contractors

n. Other special trade contractors.

(1) Structural steel erection contractors. Establishments primarily engaged in one or more of the following: (1) erecting metal, structural steel and similar products of prestressed or precast concrete to produce structural elements of building exterior, and elevator fronts; (2) setting rods, bars, rebar, mesh and cages to reinforce poured-in-place concrete; and (3) erecting cooling towers and metal storage tanks. The structural steel erection work performed includes new work, additions, alterations, reconstruction, and maintenance and repairs.

Building front installations, metal—contractors
Concrete products, structural precast or prestressed: placing of—contractors
Concrete reinforcement, placing of—contractors
Curtain wall installation—contractors
Elevator front installation, metal—contractors
Iron work, structural—contractors
Metal furring—contractors
Steel work, structural—contractors
Storage tanks, metal; erection—contractors
Storefront installation, metal—contractors

(2) Glass and glazing contractors. Establishments primarily engaged in installing glass or tinting glass. The glass work performed includes new work, additions, alterations, and maintenance and repairs.

Glass installation, except automotive—contractors
Glass work, except automotive—contractors
Glazing work—contractors
Tinting glass—contractors

(3) Excavation contractors. Establishments primarily engaged in preparing land for building construction. The excavation work performed includes new work, additions, alterations, and repairs.

Excavation work—contractors
Foundation digging (excavation)—contractors
Grading: except for highways, streets and airport runways—contractors

(4) Wrecking and demolition contractors. Establishments primarily engaged in wrecking and demolition of buildings and other structures.

Concrete breaking for streets and highways—contractors
Demolition of buildings or other structures, except marine—contractors
Dismantling steel oil tanks, except oil field work—contractors
Underground tank removal—contractors
Wrecking of building or other structures, except marine—contractors

(5) Building equipment and other machinery installation contractors. Establishments primarily engaged in one or more of the following: (1) the installation or dismantling of building equipment, machinery or other industrial equipment; (2) machine rigging; and (3) millwrighting. The building equipment and other machinery installation work performed includes new work, additions, alterations, and maintenance and repairs.

Conveyor system installation—contractors
Dismantling of machinery and other industrial equipment—contractors
Dumbwaiter installation—contractors
Dust collecting equipment installation—contractors
Elevator installation, conversion, and repair—contractors
Incinerator installation, small—contractors
Installation of machinery and other industrial equipment—contractors
Machine rigging—contractors
Millwrights
Pneumatic tube system installation—contractors
Power generating equipment installation—contractors
Revolving door installation—contractors
Vacuum cleaning systems, built-in—contractors

(6) All other special trade contractors. Establishments primarily engaged in specialized construction work. The other specialized work performed includes new work, additions, alterations, and maintenance and repairs.

Antenna installation, except household type—contractors
Artificial turf installation—contractors
Awning installation—contractors

Bathtub refinishing—contractors
Boring for building construction—contractors
Bowling alley installation and service—contractors
Cable splicing service, nonelectrical—contractors
Caulking (construction)—contractors
Cleaning building exteriors—contractors
Cleaning new buildings after construction—contractors
Coating of concrete structures with plastic—contractors
Core drilling for building construction—contractors
Countertop installation—contractors
Dampproofing buildings—contractors
Dewatering—contractors
Diamond drilling for building construction—contractors
Epoxy application—contractors
Erection and dismantling of forms for poured concrete—contractors
Fence construction—contractors
Fire escape installation—contractors
Fireproofing buildings—contractors
Forms for poured concrete, erection and dismantling—contractors
Gas leakage detection—contractors
Gasoline pump installation—contractors
Glazing of concrete surfaces—contractors
Grave excavation—contractors
House moving—contractors
Insulation of pipes and boilers—contractors
Lead burning—contractors
Lightning conductor erection—contractors
Mobile home site setup and tie down—contractors
Ornamental metal work—contractors
Paint and wallpaper stripping—contractors
Plastic wall tile installation—contractors
Posthole digging—contractors
Sandblasting of building exteriors—contractors
Scaffolding construction—contractors
Service and repair of broadcasting stations—contractors
Service station equipment installation, maintenance and repair—contractors
Shoring and underpinning work—contractors
Spectator seating installation—contractors
Steam cleaning of building exteriors—contractors
Steeplejacks
Swimming pool construction—contractors
Television and radio stations, service and repair of—contractors
Test boring for construction—contractors
Tile installation, wall: plastics—contractors
Waterproofing—contractors
Weatherstripping—contractors
Welding contractors, operating at site of construction
Window shade installation—contractors

23.82(3) *The assignment of standard industrial codes.* Each operating establishment is assigned an industry code on the basis of its primary activity, which is determined by its principal product or group of products produced or distributed, or services rendered. Ideally, the principal product or service should

be determined by its relative share of value added at the establishment. Since this is not possible for all sectors of the economy, the following should be used as a guide for determining industry codes:

Division	Data Measure
Agriculture, forestry and fishing (except agricultural services)	Value of production
Mining	Value of production
Construction	Value of production
Manufacturing	Value of production
Transportation, communication, electric, gas and sanitary services	Value of receipts or revenues
Wholesale trade	Value of sales
Retail trade	Value of sales
Finance, insurance, and real estate	Value of receipts
Service (including agricultural services)	Value of receipts or revenues
Public administration	Employment or payroll

In some cases it will not be possible to determine even on an estimated basis the value of production or similar appropriate measure for each product or service. In other cases an industrial classification based on measures of output will not accurately reflect the importance of the diversified activities. In these cases, employment or payroll should be used in lieu of the normal basis for determining the primary activity and subsequent code assignment of the establishment.

This rule is intended to conform to federal changes in the North American Industry Classification System and implements Iowa Code sections 96.7(2), 96.7(3), 96.7(4) and 96.11(1).

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◊ Two or more ARCs

[1] Agency rescinded prior to effective date

CHAPTER 24
CLAIMS AND BENEFITS

[Prior to 11/17/75, Ch 3]
[Prior to 9/24/86, Employment Security[370]]
[The filed emergency amendments were rescinded and the amendments to Chapter 4 were adopted following Notice, 12/31/86 IAB, effective 2/4/87]
[Prior to 3/12/97, Job Service Division [345] Ch 4]

871—24.1(96) Definitions. Unless the context otherwise requires, the terms used in these rules shall have the following meaning. All terms which are defined in Iowa Code chapter 96 shall be construed as they are defined in Iowa Code chapter 96.

24.1(1) *Additional claim.* An application for determination of eligibility filed on an established claim which follows a period of employment.

24.1(2) *Administrative office (state).* Same as central office.

24.1(3) *Agent state.* The state in which a worker claims benefits against another (liable) state through the facilities of the state employment security agency. See also liable state.

24.1(4) Reserved.

24.1(5) *Annual benefit amount.* See maximum annual benefits under benefits.

24.1(6) *Appeals.* See rule 871—26.1(96).

a. Administrative appeal. A request for a review by an appeals authority of a state employment security agency's determination on a claim for benefits, on a status report, or on an employer's contribution rate, or a request for a review by a higher appeals authority of a decision made by a lower appeals authority.

b. Employment appeal board of the department of inspections and appeals. The employment appeal board of the department of inspections and appeals is established to hear and decide disputed claims. The employment appeal board of the department of inspections and appeals will consist of three members appointed by the governor with the approval of two-thirds of the members of the senate. One member will represent the general public, one member will represent employers, and one member will represent employees.

This subrule is intended to implement Iowa Code section 96.6(4).

24.1(7) *Applicant.* Any individual applying for work at a workforce development center.

24.1(8) and **24.1(9)** Reserved.

24.1(10) *Average weekly wages.* See wages.

24.1(11) *Base period.* The period of time in which the amount of wages paid to an individual in insured work which determines an individual's eligibility for, and the amount and duration of, benefits. The base period consists of the first four of the last five completed calendar quarters immediately preceding the calendar quarter in which the individual's claim for benefits is effective with the following exception. The department shall exclude three or more calendar quarters from the individual's base period in which the individual received workers' compensation or indemnity insurance benefits and substitute consecutive calendar quarters immediately preceding the base period in which the individual did not receive workers' compensation or indemnity insurance benefits. This exception applies under the following conditions:

a. The individual did not work in and receive wages from insured work for three calendar quarters of the base period, or

b. The individual did not work in and receive wages from insured work for two calendar quarters and lacked qualifying wages from insured work to establish a valid claim for benefits during another quarter of the base period.

24.1(12) *Base period employer and chargeable employer.*

a. Base period employer. An employer who paid wages for employment to a claimant during the claimant's base period or an employer who is responsible for an individual's wages pursuant to Iowa Code section 96.3, subsection 5, pertaining to workers' compensation benefits.

b. Chargeable employer. An employer who had base period wages accruing to the employer's account due to an employer liability determination.

24.1(13) *Benefit amount.*

a. Maximum weekly benefit amount. The highest weekly benefit amount provided in a state employment security law.

b. Minimum weekly benefit amount. The lowest weekly benefit amount for a week of total unemployment provided in a state employment security law.

c. Weekly benefit amount. The full amount of benefits a claimant is entitled to receive for a week of total unemployment.

24.1(14) *Benefit decision.* The decision reached by a lower or higher appeals authority with respect to an appealed claim. See also benefit determination, under determination.

24.1(15) *Benefit determination.* See determination.

24.1(16) *Benefit eligibility conditions.* Statutory requirements which must be satisfied by an individual with respect to each week of unemployment before benefits can be received.

24.1(17) *Benefit formula.* The combination of mathematical factors specified in the state employment security law as the basis for computing an individual's weekly benefit amount and maximum benefit amount.

a. Annual wage formula. A benefit formula which uses the claimant's total wages in insured work for a one-year period for computing the claimant's maximum benefit amount.

b. High quarter formula. A benefit formula which uses, for determining a claimant's weekly benefit amount, the quarter of the base period in which the claimant's wages in insured work were highest.

24.1(18) *Benefits.* Money payments to an individual with respect to unemployment.

a. Regular benefits. Benefits payable to an individual under this or any other state law (including benefits payable to federal civilian employees and ex-servicemembers pursuant to 5 U.S.C., chapter 85) other than extended benefits.

b. Extended benefits. Benefits payable to an individual (including benefits payable to federal civilian employees pursuant to 5 U.S.C., chapter 85) for weeks of unemployment which begin in an extended benefit period, which is a period when extended benefits are paid in this state.

24.1(19) *Benefit wages.* See wages.

24.1(20) *Benefit year.* That period to which the limitation of maximum duration of benefits is applicable, a year or approximately a year.

24.1(21) *Benefit year, individual.* The benefit year is a period of 365 days (366 in a leap year) beginning with and including the starting date of the benefit year. The starting date of the benefit year is always on Sunday and is usually the Sunday of the current week in which the claimant first files a valid claim unless the claim is backdated as allowed under subrule 24.2(1), paragraph *"h."*

24.1(22) *Calendar week.* See week.

24.1(23) *Central office.* The state administrative office of the division of unemployment insurance services of the department of workforce development.

24.1(24) Reserved.

24.1(25) *Claim.* A request for benefit payment; also used to mean any notice filed by an individual to establish insured status or a notice filed by an individual to inform the administrative agency of the individual's unemployment.

a. A claim may be filed under any one or more of the following programs:

(1) The state program of unemployment insurance (UI),

(2) The federal program of unemployment compensation for federal employees (UCFE) established by Title V of the United States Code, and

(3) The federal program of unemployment compensation for ex-military personnel (UCX) established by Title V of the United States Code.

b. Unless otherwise specified, the term claim as used in the following definitions is applicable equally to each of the three programs.

(1) *Additional UI, UCFE, or UCX claim.* A notice filed at the beginning of a second or subsequent series of claims within a benefit year, when a break in job attachment has occurred since the last claim was filed, concerning which state procedures require that separation information be obtained.

(2) *Additional claim.* An application for determination of eligibility filed on an established claim which follows a period of employment.

(3) *Additional interstate claim.* A claim filed by an interstate claimant within the benefit year of a liable state in which insured status has already been established, after a break in the continuity of filing continued interstate claims, or to establish a new series of claims against that liable state from a new agent state.

(4) *Appealed claim.* See appeal, administrative.

(5) *Combined wage claim.* A claim filed under the interstate wage combining plans. See interstate agreement.

(6) *Compensable claim.* A request for benefit payment which certifies the completion of a week of total or partial unemployment to satisfy a claim benefit for a compensable week.

(7) *Contested claim.* A claim which has been protested by an employer, the department or an interested party regarding the claimant's right to benefits.

(8) *Continued claim.* A continued claim is a request for benefit payment. A continued claim is a compensable claim. It is an electronic, oral or written application which certifies to the completion of a week of total unemployment or partial employment to claim benefits for a compensable week.

(9) *Initial claim.* An application for a determination of eligibility for benefits which determination sets forth the weekly benefit amount and duration of benefits for a benefit year.

(10) *Initial interstate claim.* A new or an additional interstate claim.

(11) *Interstate claim.* A claim filed in one state (agent state) against another state (liable state).

(12) *Intrastate claim.* A claim filed in the state of residence against wages earned in that state or by an interstate commuter.

(13) *Mail claim.* A claim filed by mail.

(14) *New claim.* An application for the establishment of a benefit year.

(15) *New interstate claim.* The first interstate claim filed by a claimant against a liable state which serves as a request for determination of insured status.

(16) *New intrastate extended benefits claim.* The first intrastate claim filed for extended benefits in a new extended benefits period by a claimant in state having extended benefits provisions in its law. Each time such provisions become effective it is considered a new extended benefit period. Such first claims will include those which become effective, without any break in the benefit series, for the week following the week in which regular benefits are exhausted or are terminated by the end of the benefit year.

(17) *New UI, UCFE, or UCX claim.* A request for determination of insured status for purposes of establishing a new benefit year.

(18) *Reopened claim.* The first continued claim in a second or subsequent series of claims in a benefit year when no additional claim is reportable. An application for determination of eligibility for benefits and which certifies to the beginning date of a period of unemployment which falls within a benefit year previously established for which a continued claim or claims may be filed and which follows a break in a claim series previously established, due to illness, disqualification, unavailability, or failure to report for any reason other than reemployment.

(19) *Subsequent benefit year claim.* A new claim with an effective date for a subsequent benefit year which immediately follows the last week of the individual's previous benefit year. The individual is notified by mail of the transition between the benefit years and is requested to provide the department with the information which has changed from the previous benefit year's claim for benefits.

(20) *Transitional claim.* A new claim dated as of any date in the seven-day period immediately following a week benefits were claimed.

(21) *Valid UI, UCFE or UCX claim.* A new claim on which a determination has been made that the individual has met the wage or employment requirements (and, under some laws, other eligibility conditions) to establish a benefit year.

(22) *Voice response continued claim.* Rescinded IAB 8/6/03, effective 9/10/03.

24.1(26) *Claimant.*

a. An individual who has filed a request for determination of insured status or a new claim, or,

b. An individual who has filed an initial claim unless the claim is found to be invalid or the benefit year has expired.

c. Courtesy claimant. See transient claimant.

d. Transient claimant. A transient claimant is defined as one who is moving from place to place and who indicates to the agent-state local office that the stay will be only temporarily in the area served by that office. Unlike a visiting claimant, a transient claimant does not have the intrastate claim forms and instructions from the regular reporting local office. Refer to subrule 24.23(36).

e. Visiting claimant. A visiting claimant is one who has received permission from the regular reporting office to report temporarily to a local office of another state and who has been furnished intrastate claim forms on which to file claims.

24.1(27) Reserved.

24.1(28) *Claim series*. A series of claims filed for continuous weeks of unemployment or for a period of unemployment during which the lapse in compensability or in reporting is deemed by the state insufficient to interrupt the series.

24.1(29) *Compensable claim.* See claim.

24.1(30) *Compensable week.* See week.

24.1(31) *Compensation.* Same as benefits.

24.1(32) *Contested claim.* See claim.

24.1(33) *Continued claim.* See claim.

24.1(34) *Covered employment.* Same as insured work.

24.1(35) *Covered worker.* An individual who has earned wages in insured work.

24.1(36) *Day.* The period of time between any midnight and the midnight following.

24.1(37) *Department.* The chief executive officer of the department of workforce development is the director who shall be appointed by the governor with the approval of two-thirds of the members of the senate. It shall be the duty of the director to administer Iowa Code chapter 96.

24.1(38) *Determination.*

a. Benefit determination. A decision with respect to a request for determination of insured status, a notice of unemployment, or a claim for benefits.

b. Coverage determination. A determination as to whether an employing unit is a subject employer and whether service performed for it constitutes employment as defined under a state employment security law. See status determination.

c. Determination of insured status. A determination as to whether an individual meets the employment requirements necessary for the receipt of benefits; and, if so, such individual's weekly benefit amount and maximum benefit amount.

d. Initial determination. The first determination with respect to a claim or a request for determination of insured status.

e. Monetary determination. Same as determination of insured status.

f. Nonmonetary determination. A determination as to whether a claimant is barred from receiving benefits for reasons other than those affecting the claimant's insured status.

g. Reconsidered determination. Same as redetermination.

h. Redetermination. A determination made with respect to a claimant after reconsideration by the initial determining authority.

i. Status determination. A determination as to whether an employing unit whose status is not known is a subject employer.

24.1(39) *Disqualification provisions.* Those provisions of a state employment security law that set forth the conditions that bar an individual from receiving benefits for a specified period or cancel or reduce the individual's benefits or credits.

24.1(40) *Duration of benefits.* The number of weeks for which benefits are paid or payable for total unemployment in a benefit year. Because there may be deductible wages and other compensation, duration is often described in terms of the total amount of benefits arrived at by multiplying the weekly benefit amount by the number of weeks of total unemployment.

a. Actual duration. The number of full weeks of benefits received by an individual, or the equivalent thereof expressed in terms of dollars.

b. Maximum duration. The highest number of weeks of total unemployment for which benefits are payable to any individual in a benefit year under a state employment security law.

24.1(41) *Earnings limit.* An amount equal to the weekly benefit amount plus $15.

24.1(42) *Eligibility requirements.* Same as benefit eligibility conditions.

24.1(43) *Employment interview.* A conversation between an applicant and an interviewer directed toward obtaining and recording information pertinent to classification and selection, and giving information pertinent to job seeking.

24.1(44) *Employment office.* An office maintained by the department of workforce development in accordance with Iowa Code sections 96.12 and 96.25.

24.1(45) *Employment security administration fund.* See funds.

24.1(46) *Employment security law.* A body of law which establishes a free public employment service, or a system of unemployment insurance, or both and which may also establish other systems compensating for wage loss, such as temporary disability insurance in Iowa Code chapter 96.

24.1(47) *Employment security program.* The federal-state program comprising public employment services and unemployment insurance.

24.1(48) *Fact-finding interview.* A face-to-face or telephonic discussion between interested parties and a department representative for the purpose of obtaining from the claimant a statement containing information on a specific eligibility or disqualification issue. This differs from an eligibility review interview in that a specific issue must exist as a result of a statement made by either the claimant, the liable state, an employer, or the staff of the department.

24.1(49) *First UI, UCFE, or UCX payment.* A payment issued to a claimant for the first compensable week of unemployment in a benefit year.

24.1(50) *Full-time week.* See week.

24.1(51) *Funds.*

a. Administrative funds. Funds made available from federal, state, local and other sources to meet the cost of state employment security administration.

b. Contingency fund. An amount of money appropriated by Congress to meet certain unpredictable increases in costs of administration by the state employment security agencies arising from increases in workload or other specified causes.

c. Special employment security contingency fund. A contingency fund established pursuant to Iowa Code section 96.13(3) into which all interest, fines, and penalties are paid.

d. Employment security administration fund. A special fund in the state treasury, established by state law, in which are deposited moneys granted by the manpower administration and monies from other sources, for the purpose of paying the cost of administering the state employment security program.

e. Title V funds. Funds appropriated by Congress to pay unemployment insurance benefits under Title V of the United States Code to federal, civilian and military employees.

f. Unemployment fund. A special fund established under a state employment security law for the receipt and management of contributions and the payment of unemployment account, clearing account, and unemployment trust fund account.

g. Unemployment trust fund. A fund established in the treasury of the United States which contains all moneys deposited with the treasury by state employment security agencies to the credit of their unemployment fund accounts and by the railroad retirement board to the credit of the railroad unemployment insurance account.

24.1(52) *Handbook.* The handbook for interstate claims-taking provided by the Employment and Training Administration of the United States Department of Labor.

24.1(53) *High quarter formula.* See benefit formula.

24.1(54) to **24.1(56)** Reserved.

24.1(57) *Individual base period.* See base period.

24.1(58) *Individual benefit year.* See benefit year.

24.1(59) *Initial claim.* See claim.

24.1(60) *Initial determination.* See determination.

24.1(61) *Insured unemployment.* Unemployment during a given week for which benefits are claimed under the state employment security program, the unemployment compensation for federal employees program, the unemployment compensation for veterans program, or the railroad unemployment insurance program.

24.1(62) *Insured work.* Employment, as defined in a state employment security law, performed for a subject employer, or federal employment as defined in the Social Security Act.

24.1(63) *Insured worker.* An individual who has had sufficient insured work in such individual's base period to meet the employment requirements for receipt of benefits under a state employment security law.

24.1(64) *Interstate agreement.*

a. Interstate benefit payment plan. The plan under which each state acts as an agent for every other state in taking claims for individuals who are not in the state in which they earned their base period wages.

b. Interstate reciprocal coverage agreement. An administrative interstate agreement, permitted under most state employment security laws, which provides for the election of coverage of services under specified conditions which may or may not constitute an exception to the mandatory coverage provisions of the state law.

c. Wage-combining agreements. An interstate agreement which allows workers who lack qualifying wages in any one state, or who qualify for less than maximum benefits in one or more states, to qualify or to increase benefits by combining wages from all states.

24.1(65) *Interstate claim.* See claim.

24.1(66) *Interstate claimant.* An individual who files a claim for benefits in an agent state on the basis of employment covered by the employment security law of a liable state.

24.1(67) *Benefit rights information.* Information provided to a claimant for the purpose of explaining the claimant's rights and responsibilities under the law. Such information may be given on a group basis or on an individual basis or the information may be provided electronically.

24.1(68) *Office.*

a. Unemployment insurance service center. A full-time office staffed with workforce development staff to provide unemployment insurance services to the public.

b. Workforce development center. A full-time office staffed with workforce development personnel to provide unemployment insurance or job placement service to the public.

24.1(69) *Lag quarter.* The completed quarter between a claimant's base period and the quarter which includes the beginning date of such claimant's benefit year.

24.1(70) *Layoffs.* See separations.

24.1(71) *Liable state.* Any state against which a worker claims benefits through the facilities of a workforce development center or the job service division of another (agent) state. See also agent state.

24.1(72) *Mail claim.* See continued claims.

24.1(73) *Mass separation.* The separation from a given employing unit of a large number of workers at approximately the same time and for a reason common to all such workers.

24.1(74) *Mass separation notice.* A report of a mass separation sent to the local workforce development center by an employer, stating the number of workers separated and listing their names and other required data. Such a notice serves as a substitute for individual separation notices.

24.1(75) *Maximum benefit amount.* The maximum total amount of benefits an individual may receive during the individual's benefit year.

24.1(76) *Maximum benefits.* The maximum total amount of benefits payable to a claimant during the claimant's benefit year.

24.1(77) *Maximum weekly benefit amount.* See benefit amount.

24.1(78) *Microfiche.* Rescinded IAB 8/6/03, effective 9/10/03.

24.1(79) *Military separations.* See separations.

24.1(80) *Minimum weekly benefit amount.* See benefit amount.

24.1(81) *Month.* The time beginning with any day of one month to the corresponding day of the next month, or if there is no corresponding day, then through the last day of the next month.

24.1(82) *Multistate worker.* An individual who performs service for one employer in more than one state.

24.1(83) *New claim.* See claim.

24.1(84) *Noncovered employment.* Excluded employment, or employment for an employer below the size-of-firm coverage requirements of the state employment security law.

24.1(85) *Notice of separation.* A report submitted by an employer at the time when a worker is separated from employment, on which the employer indicates the dates of the last day worked, the separation date and the reason the worker was separated.

24.1(86) *Odd job earnings.* Any earnings which a claimant may have during a week of unemployment as a result of temporary work with an employing unit other than the claimant's regular employing unit.

24.1(87) *Opening.* A single job for which a workforce development center has on file a request to select and refer an applicant or applicants.

24.1(88) *Outstanding job order request.* An active request for referral of one or more applicants to fill one or more job openings in a single occupational classification; also, the record of such request.

24.1(89) *Clearance order.* Rescinded IAB 8/6/03, effective 9/10/03.

24.1(90) *Partial benefits.* Benefits payable to an individual for a week of partial unemployment.

24.1(91) *Partial earnings allowance.* The amount of earnings that are disregarded in calculating a claimant's benefit for a week.

24.1(92) *Partial unemployment.* See week of unemployment.

24.1(93) *Part-time worker.* A person engaged in, or available only for, part-time work.

24.1(94) *Placement.* An acceptance by an employer of a person for a job as a direct result of workforce development center activities, provided the employment office has completed all of the following four steps: receipt of an order, prior to referral; selection of the person to be referred without designation by the employer of any particular individual or group of individuals; referral; and verification from a reliable source, preferably the employer, that a person referred has been hired by the employer and has entered on the job.

24.1(95) Reserved.

24.1(96) *Qualifying employment.* The amount of insured work which an individual must have had within a specified period in order to be an insured worker. See also benefit eligibility conditions.

24.1(97) *Qualifying wages.* See wages.

24.1(98) *Quits.* See separations.

24.1(99) *Railroad unemployment insurance account.* An account, established pursuant to the Railroad Unemployment Insurance Act, maintained in the federal unemployment trust fund for the payment of benefits provided in that Act.

24.1(100) *Readout.* Printed data from the claimant database or other types of records stored in the computer.

24.1(101) *Reciprocal coverage agreement.* See interstate agreements.

24.1(102) *Reconsidered determination.* Same as redetermination—see determination.

24.1(103) *Referee appeals.* See appeal, administrative. (Administrative law judge)

24.1(104) *Referral.* The act of arranging to bring to the attention of an employer (or another workforce development center) the qualifications of an applicant who is available for a job opening on file for which the applicant has been selected by a workforce development center.

24.1(105) *Registration.* The process of applying for work through an office of the department of workforce development.

24.1(106) *Report to determine liability.* Same as status report.

24.1(107) *Reporting requirements.* The rules of procedures of the department of workforce development concerning the frequency and time of required reporting by claimants.

24.1(108) *Renewal.* The transfer from the inactive to the active file of the application of an applicant who is again considered to be available for referral to job openings.

24.1(109) *Request for determination of insured status.* A request by an individual for a determination of insured status.

24.1(110) *Selection.* The process of choosing a qualified applicant for referral to a job by carefully analyzing and comparing employer requirements with applicant interests and abilities.

24.1(111) *Self-employment.*

24.1(112) *Self-filing (of claim).* The partial or complete filling out of a claim form or request for determination of insured status by the claimant.

24.1(113) *Separations.* All terminations of employment, generally classifiable as layoffs, quits, discharges, or other separations.

a. Layoffs. A layoff is a suspension from pay status initiated by the employer without prejudice to the worker for such reasons as: lack of orders, model changeover, termination of seasonal or temporary employment, inventory-taking, introduction of laborsaving devices, plant breakdown, shortage of materials; including temporarily furloughed employees and employees placed on unpaid vacations.

b. Quits. A quit is a termination of employment initiated by the employee for any reason except mandatory retirement or transfer to another establishment of the same firm, or for service in the armed forces.

c. Discharge. A discharge is a termination of employment initiated by the employer for such reasons as incompetence, violation of rules, dishonesty, laziness, absenteeism, insubordination, failure to pass probationary period.

d. Other separations. Terminations of employment for military duty lasting or expected to last more than 30 calendar days, retirement, permanent disability, and failure to meet the physical standards required.

24.1(114) *Short-time placement.* A placement in a job which the employer expects to involve work in each of three days or less, whether or not consecutive.

24.1(115) *Social security number.* The identification number assigned to an individual by the Social Security Administration under the Social Security Act.

24.1(116) *Status determination.* See determination.

24.1(117) *Supplemental benefit payment.* A payment issued for the sole purpose of adjusting an underpayment for one or more previous weeks.

24.1(118) *Taxable wages.* See wages.

24.1(119) *Total unemployment.* See week of unemployment.

24.1(120) Reserved.

24.1(121) *Transient.* A claimant who is moving from place to place and who indicates to the agent-state area claims office that such claimant will be only temporarily in the area served by the area office.

24.1(122) *Unemployment fund.* See funds.

24.1(123) *Unemployment trust fund.* See funds.

24.1(124) *Unemployment trust fund account.* See accounts.

24.1(125) *Valid claim.* See claim.

24.1(126) *Verification.* The determination from a reliable source, preferably the employer, whether an applicant referred by a workforce development center has been hired by the employer and has entered on the job. In the case of applicants referred to seasonal agricultural openings, verification is considered complete when it is confirmed that a referred worker has been hired, even though confirmation of the worker's entry on the job may be lacking.

24.1(127) *Visiting claimant.* A claimant who files claims against such claimant's home state through some extension of that state's intrastate claims procedures.

24.1(128) *Wage combining agreement.* See interstate agreement.

24.1(129) *Wage credits.* Wages earned in insured work.

24.1(130) *Wages.* Average weekly wages.

a. For an individual worker, the result obtained by dividing the individual's total wages in a specified period either by the total number of weeks in the period or by the number of weeks for which wages were payable to the individual during the period.

b. For a group of workers, the result obtained by dividing the total wages for one or more quarters by the number of weeks in the period, and then dividing by the average monthly employment during the period.

24.1(131) *Qualifying wages.* The amount of wages a worker must have earned in insured work within a specified period in order to be an insured worker. See also benefit eligibility conditions.

24.1(132) *Taxable wages.* Wages subject to contribution under a state employment security law, or wages subject to tax under the federal Unemployment Tax Act.

24.1(133) Reserved.

24.1(134) *Weekly indemnity insurance benefits.* Payment for nonoccupational illness or injury pursuant to a benefit plan implemented by an employer.

24.1(135) *Week.* A seven-day period beginning at 12:01 a.m. on Sunday and terminating at midnight on the following Saturday.

a. Calendar week. A period of seven consecutive days usually ending at Saturday midnight, used by some state employment security agencies as a unit in the measurement of employment or unemployment.

b. Compensable week. A week for which benefits have been claimed.

c. Full-time week. The number of hours or days per week currently established by schedule, custom, or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

24.1(136) *Weekly benefit amount.* See benefit amount, or,

24.1(137) *Weekly benefit amount.* The compensation payable to an individual, with respect to employment, under the employment security law of any state.

24.1(138) *Week of unemployment.* A week in which an individual performs less than full-time work for any employing unit if the wages payable with respect to such week are less than a specified amount (usually the weekly benefit amount), or,

24.1(139) *Week of unemployment.* A week during which an individual performs no work and earns no wages, except as indicated and has earnings which do not exceed the earnings limit.

a. Week of partial unemployment. A week in which an individual worked less than the regular full-time hours for such individual's regular employer, because of lack of work, and earned less than the weekly benefit amount (plus the partial earnings allowance, if any, in the state's definition of unemployment) but more than the partial earnings allowance, so that, if eligible for benefits, the claimant received less than such claimant's full weekly benefit amount plus $15.

b. Week of part total unemployment. A week of otherwise total unemployment during which an individual has odd jobs or subsidiary work with earnings in excess of the amount specified in the state law as allowable without resulting in a reduction in the individual's benefit payment.

c. Week of total unemployment. A week in which an individual performs no work and earns no wages.

24.1(140) *Workload.* The measure of the volume of work for each functional area of the state agency; i.e., the number of contribution (payroll) reports processed, the number of claims taken, the number of applications for employment.

This rule is intended to implement Iowa Code sections 96.3(5), 96.3(7), 96.4(3), 96.5(5)*"c,"* 96.6, 96.7(2)*"a"*(2), 96.11, 96.19(16), and 96.23.

871—24.2(96) Procedures for workers desiring to file a claim for benefits for unemployment insurance.

24.2(1) Section 96.6 of the employment security law of Iowa states that claims for benefits shall be made in accordance with such rules as the department prescribes. The department of workforce development accordingly prescribes:

a. Following separation from work, any individual, in order to establish a benefit year during which the individual may receive benefits because of unemployment shall report in person to the nearest workforce development center which takes claims and shall file an initial claim for benefits and register for work.

(1) An individual may file an initial claim for unemployment benefits by telephone, in person or other means prescribed by the department or may call the service center during regular business hours. Claims filed in accordance with this rule shall be deemed filed as of Sunday of the week in which the claim is filed.

(2) Reserved.

b. The procedure for filing an initial claim. An individual, following a separation from work, shall report in person at the nearest workforce development center with the individual's social security number, and the individual shall register for work and file a claim for benefits on the Form 60-0330, Application for Job Placement Assistance and/or Job Insurance, prescribed by the department and shall provide, in addition to other requested information, the following information:

(1) The name and complete mailing address of such individual's last employing unit or employer;

(2) The location of the last job;

(3) Last day of work;

(4) The reason for separation from work;

(5) That such individual is unemployed;

(6) That the individual registers for work;

(7) The individual's last job occupation;

(8) Number, name and relationship of any dependents claimed. As used in this subparagraph, "dependent" is defined as: spouse, son or daughter of the claimant, or a dependent of either; stepson or stepdaughter; foster child or child for whom claimant is a legal guardian; brother, sister, stepbrother, stepsister; father or mother of claimant, stepfather or stepmother of the claimant; son or daughter of a brother or sister of the claimant (nephew or niece); brother or sister of the father or mother of the claimant (uncle or aunt); son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the claimant; an individual who lived in the claimant's home as a member of the household for the whole year; cousin.

A "spouse" is defined as an individual who does not earn more than $120 in gross wages in one week. The reference week for this monetary determination shall be the gross wages earned by the spouse in the calendar week immediately preceding the effective date of the claim.

A "dependent" means an individual who has been or could have been claimed for the preceding tax year on the claimant's income tax return or will be claimed for the current income tax year. The same dependent shall not be claimed on two separate monetarily eligible concurrent established benefit years. An individual cannot claim a spouse as a dependent if the spouse has listed the claimant as a dependent on a current claim.

(9) The option of filing for continued benefits by using the voice response continued claim system or by other means designated by the department.

(10) Such other information as required by the form.

c. All claimants on an initial claim shall state that they are registered for work and shall list their principal occupation. The claims taker will then assign a group code to the claimant to control the type of registration that is made. Code assignments will be based on all facts obtained at the time of the claim filing. The group codes are:

(1) Group "1" claimants are workers who have a definite attachment to a specific employer or trade and have reasonable employment prospects in a reasonable period of time. These claimants will be registered for work.

(2) Group "2" claimants are those individuals who do not otherwise meet the qualification for group "1," "3," "4," "5," or "6" under this section. Group "2" claimants may also include the following: claimants who were employed in demand occupations; irregular employment record (in reference to occupation); delay in claim filing; moved to address remote from labor market or transportation problems; unfavorable job prospects because of recent arrival in locality; farming activities; self-employment assuming otherwise eligible; students or prospective students; pensioners; domestic care or problems; previous fraud or overpayment record; physical impairment or poor health which would limit employability; personal or other restrictions (wages, hours, travel).

(3) Group "3" claimants are workers who are employed on a reduced workweek or temporarily unemployed for a period, verified by the department, of four consecutive weeks or less, due to a plant shutdown, vacation, inventory, lack of work or emergency from the individual's regular "employer." This group pertains only to those individuals who worked full-time and will again work full-time if the individual's employment, although temporarily suspended, has not been terminated. After a period of temporary unemployment, claimants in this group are reviewed for placement in group "1," "2," "5" or "6."

(4) Group "4" claimants are those individuals who have left employment in lieu of exercising their right to bump or oust a fellow employee with less seniority or priority from the fellow employee's job. Group "4" claimants with an individual benefit year starting prior to July 1, 1984, shall be able to work, available for work and have the search for work provisions of Iowa Code section 96.4(3) waived. Group "4" claimants with an individual benefit year starting on or after July 1, 1984, shall have only the search for work provision of Iowa Code section 96.4(3) and the disqualification provision for failure to apply for or to accept suitable work of Iowa Code section 96.5(3) waived. The group "4" code shall not apply to weeks claimed under the extended benefit or federal supplemental compensation programs.

(5) Group "5" claimants are those individuals who are members of unions, trades, or professionals having their own placement facilities. Claimants assigned to this group will be registered for work. A paid-up membership is acceptable as evidence of membership in such an organization. Loss of membership shall result in an assignment to group "2."

(6) Group "6" claimants are those individuals whose occupations are of a nature that utilize résumés or who are normally unable, due to factors such as occupation, distance, etc., to make in-person contacts for employment.

(7) Nothing in this rule shall be construed as prohibiting an authorized representative of the department from requiring claimants for unemployment insurance benefits to avail themselves of workforce development center referral and counseling services if deemed beneficial and necessary to obtain prompt reemployment, nor shall anything in this rule be construed to deny referral or counseling service to claimants for unemployment insurance benefits.

d. Reserved.

e. In order to maintain continuing eligibility for benefits during any continuous period of unemployment, an individual shall report as directed to do so by an authorized representative of the department. If the individual has moved to another locality, the individual may register and report in person at a workforce development center at the time previously specified for the reporting.

The method of reporting shall be weekly if a voice response continued claim is filed, unless otherwise directed by an authorized representative of the department. An individual who files a voice response continued claim will have the benefit payment automatically deposited weekly in the individual's account at a financial institution or be paid by the mailing of a warrant on a biweekly basis.

In order for an individual to receive payment by direct deposit, the individual must provide the department with the appropriate bank routing code number and a checking or savings account number.

The department retains the ultimate authority to choose the method of reporting and payment.

f. After the initial claim has been filed, the claimant will receive from the local office or the administrative office a Form 65-5318, which is a notice of the action taken on the claim, and if such claimant is eligible for benefits this notice will state the date on which the benefit year will begin, the amount per week, and the maximum amount for which the claimant is eligible.

g. No continued claim for benefits shall be allowed until the individual claiming benefits has completed a voice response continued claim or claimed benefits as otherwise directed by the department. The weekly voice response continued claim shall be transmitted not earlier than noon of the Saturday of the weekly reporting period and, unless reasonable cause can be shown for the delay, not later than close of business on the Friday following the weekly reporting period.

An individual claiming benefits using the weekly voice continued claim system shall personally answer and record such claim on the system unless the individual is disabled and has received prior approval from the department.

The individual shall set forth the following:

(1) That the individual continues the claim for benefits;

(2) That except as otherwise indicated, during the period covered by the claim the individual was unemployed, earned no wages and received no benefits, was able to work and available for work;

(3) That the individual indicates the number of employers contacted for work;

(4) That the individual knows the law provides penalties for false statements in connection with the claim;

(5) That the individual has reported any job offer received during the period covered by the claim;

(6) Other information required by the department.

h. Effective starting date for the benefit year.

(1) Filing for benefits shall be effective as of Sunday of the current calendar week in which, subsequent to the individual's separation from work, an individual reports in person at a workforce development center and registers for work in accordance with paragraph *"a"* of this rule.

(2) The claim may be backdated prior to the first day of the calendar week in which the claimant does report and file a claim for the following reasons:

Backdated prior to the week in which the individual reported if the individual presents to the department sufficient grounds to justify or excuse the delay;

There is scheduled filing in the following week because of a mass layoff;

The failure of the department to recognize the expiration of the claimant's previous benefit year;

The individual is given incorrect advice by a workforce development employee;

The claimant filed an interstate claim against another state which has been determined as ineligible;

Failure on the part of the employer to comply with the provisions of the law or of these rules;

Coercion or intimidation exercised by the employer to prevent the prompt filing of such claim;

Failure of the department to discharge its responsibilities promptly in connection with such claim, the department shall extend the period during which such claim may be filed to a date which shall be not less than one week after the individual has received appropriate notice of potential rights to benefits, provided, that no such claim may be filed after the 13 weeks subsequent to the end of the benefit year during which the week of unemployment occurred. In the event continuous jurisdiction is exercised under the provisions of the law, the department may, in its discretion, extend the period during which claims, with respect to week of unemployment affected by such redetermination, may be filed.

(3) When the benefit year expires on any day but Saturday, the effective date of the new claim is the Sunday of the current week in which the claim is filed even though it may overlap into the old benefit year up to six days. However, backdating shall not be allowed at the change of a calendar quarter if the backdating would cause an overlap of the same quarter in two base periods. When the overlap situation occurs, the effective date of the new claim may be postdated up to six days. If the claimant has benefits remaining on the old claim, the claimant may be eligible for benefits for that period by extending the old benefit year up to six days.

i. An individual shall be entitled to partial benefits for any week of less than full-time work, provided the wages earned during such week are less than the individual's weekly benefit earning limit, plus $15. If the individual has been placed on reduced employment the individual may be entitled to partial benefits, and should file a claim in accordance with the instructions pertaining to the partial claims procedure.

j. Reserved.

k. Any individual who is disqualified for benefits because of the individual's failure to report as directed to file a claim following the date specified may appeal to the department for the right to establish good cause for failure to report because of extraordinary circumstances. A representative of the department may deny the request and the decision may be appealed to an administrative law judge for a hearing and decision on the merits. If the petition is allowed the petitioner shall be allowed to file a claim for and receive full benefits for each week for which such claim is filed, if otherwise eligible.

24.2(2) Filing a claim for unemployment insurance benefits (not applicable to interstate claims).

a. A notice of claim filing, which includes the name and social security number of the individual claiming benefits, shall be sent to each base period employer on record and the last employer if different than the base period employer unless the separation issue has previously been adjudicated.

b. Even though the claims taker may believe that the claimant cannot meet the eligibility conditions required by statute, the claims taker shall in no instance refuse to accept a claim from any unemployed individual. If the claimant elects to file a claim, even though the claimant's eligibility may be questionable, the claim shall be accepted without hesitance. The claimant must provide adequate proof of identification such as a driver's license, car registration, or union membership card or supply personally identifying information.

c. If a claim was filed in a previous quarter and was determined not eligible because of no wage records, or lack of qualifying earnings, a benefit year has not been established and a new claim will be taken. A new claim should not be taken if the claimant previously has filed an ineligible claim in the same quarter unless the claimant insists on filing after being advised of ineligibility. The claims taker shall explain to the claimant that another claim filed in the same quarter would also be determined as ineligible because additional wage credits (if any) would not be available until a subsequent quarter. The claimant should be advised to file a new claim during the first full week of the next calendar quarter.

d. If the check of the files does not disclose a previous claim and the claimant states that a claim has not been filed during the past year, a new claim shall be taken.

e. Partially unemployed claims.

(1) A partially unemployed individual shall file a claim for benefits in the same manner as an initial claim for unemployment insurance.

(2) Reporting wages. A partially unemployed individual shall report all wages which are earned for each week benefits are claimed.

(3) A claimant in a continuous reporting status, employed with the same employer, may exceed the claimant's weekly benefit amount plus $15 for four consecutive weeks before the individual is required to file an additional claim for benefits.

24.2(3) Filing a claim for unemployment insurance benefits (interstate only).

a. Initial interstate claims. The filing of an initial interstate claim shall conform to all requirements of this rule with the exception of the initial claim form. Both agent and liable states shall use the Initial Interstate Claim, Form 61-1000(IB-1), unless otherwise directed by the Interstate Handbook.

b. Rescinded IAB 8/6/03, effective 9/10/03.

24.2(4) Cancellation of unemployment insurance claim.

a. A request for cancellation of an unemployment insurance claim may be made by the individual in writing and be directed to the Unemployment Insurance Service Center, Department of Workforce Development, P.O. Box 10332, Des Moines, Iowa 50306. The statement must include the specific reason for the request and contain as much pertinent information as possible so that a decision can be made.

b. A cancellation request which is the result of employer coercion or intimidation shall be denied and the employer could be subjected to serious misdemeanor charges.

c. Cancellation requests within the ten-day protest period. The claims section, upon review of the timely request and before payment is made, may cancel the claim for the following reasons:

(1) The individual found employment or returned to regular employment within the protest period.

(2) Cancellation would allow the individual to refile at the change of a calendar quarter to obtain an increase in the weekly or maximum benefit amount or the individual would receive more entitlement from another state.

(3) The individual filed a claim in good faith under the assumption of being separated and no actual separation occurred.

(4) The individual did not want to establish a benefit year because of eligibility for a low weekly or maximum benefit amount.

d. Other valid reasons for cancellation whether or not ten-day protest period has expired.

(1) The individual has an unexpired unemployment insurance claim in another state and is eligible for a remaining balance of benefits.

(2) The individual received erroneous information regarding entitlement or eligibility to unemployment insurance benefits from an employee of the department.

(3) The individual has an unexpired railroad unemployment insurance claim with a remaining benefit balance which was filed prior to the unemployment insurance claim.

(4) The individual exercises the option to cancel a combined wage claim within the ten days allowed by federal regulation.

(5) The individual has previously filed a military claim in another state or territory. Wages erroneously assigned to Iowa must be deleted and an interstate claim must be filed.

(6) Federal wages have previously been assigned to another state or territory or are assignable to another state or territory under federal regulation. Federal wages erroneously assigned to Iowa must be deleted and the appropriate type of claim filed.

(7) The Iowa wages are erroneous and are deleted and the wages from one other state were used, the claim shall be canceled and the wages returned to the transferring state.

e. If a claim is canceled and becomes final with no appeal being filed, a valid claim with Iowa as the paying state shall not be reestablished with the same effective date.

f. Voiding a claim. If it is determined a claim has been filed under an incorrect social security number, the claim shall be voided rather than canceled.

g. All unemployment insurance claims canceled shall be clearly identified as such and the administrative record of the individual's file shall be destroyed three years after final action.

This rule is intended to implement Iowa Code sections 96.3(3), 96.3(4), 96.4(1), 96.4(3), 96.5(1)*"h,"* 96.5(3), 96.6(1), 96.6(2), 96.15, 96.16, 96.19(4), 96.19(24), and 96.20.

871—24.3(96) Social security number needed for filing.

24.3(1) The claims taker must have the social security number of the claimant. The correct social security number is essential in the processing of the claim. Therefore, if the claimant has a social security card, the number must be taken from that card or be provided by the claimant. If the claimant has two or more social security numbers, the claim shall be held until the claimant ascertains which number is correct.

24.3(2) When a claimant does not have a social security card and no other record of the claimant's social security number is available the claims taker shall advise the claimant that the number may be available from the claimant's employer.

24.3(3) In all such instances, the claims taker shall take the claim and hold it pending receipt of the social security number for a period not to exceed 30 days. If no number is provided by the claimant within 30 days, the claims taker shall submit the claim without a number. Such claims will be determined as ineligible (no wage credits).

24.3(4) and **24.3(5)** Rescinded IAB 8/6/03, effective 9/10/03.

24.3(6) The department will assist the claimant in every reasonable manner so that the claim may be processed in the shortest possible time.

871—24.4(96) Benefit rights information.

24.4(1) *Intrastate benefits.* Benefit rights information is provided to each individual filing an initial claim for benefits to explain those provisions in the law and rules which govern the individual's monetary eligibility, rights and responsibilities under Iowa's unemployment insurance program. The benefit rights information may be given by an individual or group type interview or by telephone or electronically. A Form 70-6200, Facts About Unemployment Insurance, will be provided which explains the individual's rights, benefits, and responsibilities under Iowa's unemployment insurance program.

24.4(2) *Interstate benefits.* Benefit rights information is not required for each individual who files an initial claim for interstate benefits. Claimants will be advised to contact the liable state which will provide additional information explaining the individual's rights, benefits, and responsibilities under the liable state's unemployment insurance program.

24.4(3) *Federal benefits.* Rescinded IAB 8/6/03, effective 9/10/03.

871—24.5(96) Mass separation—definition and procedure.

24.5(1) *Mass separation.* A mass separation is a layoff of all or a large number of workers, either permanently, indefinitely, or for a specific duration by one or more employers in the same area, at approximately the same time, and for the same common reason.

a. The special procedures for mass claim filing may be applied by the department, and the procedures may include taking claims at a designated site or utilizing an electronic mass claim entry form.

b. If other facilities must be obtained for a mass layoff, the order of precedence for obtaining such facilities will be as follows:

(1) Interested employer involved.

(2) Bona fide union which represents the workers.

(3) Public facility (i.e., courthouse, city hall).

24.5(2) *Cooperation of employers.* To enable workforce development centers to make the preliminary arrangements for mass claim taking, the major employers in the area should notify the local office in advance, as soon as they know that a mass separation will take place. The workforce development center shall provide the information to legal counsel for the unemployment insurance services bureau so that the mass claim separation can be coordinated between the affected parties. This information should include:

a. The number of workers to be separated.

b. The date of separation and, if staggered, the number on each date.

c. Reason for layoff.

d. Its probable duration.

e. If recall is anticipated, the date it will begin and, if staggered, the number to be recalled on each date.

f. Rescinded IAB 8/6/03, effective 9/10/03.

g. Reserved.

h. If the layoff is for vacation or inventory purposes, the employer shall follow the vacation pay procedure in rules 24.16(96) and 24.17(96).

24.5(3) *Methods of mass claim taking.* The department may adopt a plan, which is based on the employer's workers, the circumstances and the size of the layoff.

24.5(4) *Announced mass separation.* If a mass separation occurs about which the department of workforce development has not been advised in advance in sufficient time to preschedule claimants, then the claimants will be advised of the alternative methods to file their claims as quickly as possible. The department will develop a plan to provide service to the claimants as quickly as possible under the circumstances.

This rule is intended to implement Iowa Code section 96.6(1).

871—24.6(96) Profiling for reemployment services.

24.6(1) The department of workforce development and the department of economic development will jointly provide a program which consists of profiling claimants and providing reemployment services.

24.6(2) Profiling is a systematic procedure used to identify claimants who, because of certain characteristics, are determined to be permanently separated and most likely to exhaust benefits. Such claimants may be referred to reemployment services.

24.6(3) Reemployment services may include, but are not limited to, the following:

a. An assessment of the claimant's aptitude, work history, and interest.

b. Employment counseling regarding reemployment approaches and plans.

c. Job search assistance and job placement services.

d. Labor market information.

e. Job search workshops or job clubs and referrals to employers.

f. Résumé preparation.

g. Other similar services.

24.6(4) As part of the initial intake procedure, each claimant shall be required to provide the information necessary for profiling and evaluation of the likelihood of needing reemployment assistance.

24.6(5) The referral of a claimant and the provision of reemployment services is subject to the availability of funding and limitations of the size of the classes.

24.6(6) A claimant shall participate in reemployment services when referred by the department unless the claimant establishes justifiable cause for failure to participate or the claimant has previously completed such training or services. Failure by the claimant to participate without justifiable cause shall disqualify the claimant from the receipt of benefits until the claimant participates in the reemployment services.

a. Justifiable cause for failure to participate is an important and significant reason which a reasonable person would consider adequate justification in view of the paramount importance of reemployment to the claimant.

b. Reserved.

This rule is intended to implement Iowa code section 96.4(7).

871—24.7(96) Workers' compensation or indemnity insurance exclusion and substitution.

24.7(1) An individual who has received workers' compensation under Iowa Code chapter 85 during a healing period or temporary total disability benefits or indemnity insurance benefits for an extended period of time and has insufficient wage credits in the base period may qualify for unemployment insurance benefits. Under specific circumstances as described below, the department shall exclude certain quarters in the base period and substitute three or more consecutive calendar quarters immediately preceding the base period which were prior to the workers' compensation or indemnity insurance benefits.

24.7(2) An individual may receive workers' compensation during a healing period or temporary total disability benefits or indemnity insurance benefits until the individual returns to work or is medically capable of returning to employment substantially similar to the employment in which the employee was engaged at the time of injury.

24.7(3) The department shall make an initial determination of eligibility for unemployment insurance benefits. If the individual has no wage records or lacks qualifying wage requirements, the department shall substitute three or more calendar quarters of the base period with those three or more consecutive calendar quarters immediately preceding the base period in which the individual did not receive workers' compensation benefits or indemnity insurance benefits. The qualifying criteria for substituting quarters in the base period are that the individual:

a. Must have received workers' compensation benefits under Iowa Code chapter 85 or indemnity insurance benefits for which an employer is responsible during the excluded quarters, and

b. Did not work in and receive wages from insured work for:

(1) Three or more calendar quarters in the base period, or

(2) Two calendar quarters and lacked qualifying wages from insured work during another quarter of the base period.

24.7(4) Subject to the provisions of subrule 24.7(3), the department shall use the following criteria for allowances and disqualifications.

a. Allowances. When the allowance criteria are met, the department shall always exclude and substitute at least three quarters of the base period if the individual received workers' compensation or indemnity insurance benefits in:

(1) Four base period quarters with no earnings in at least two of the quarters and the individual lacks qualifying earnings, the department will exclude and substitute all four quarters of the base period.

(2) Three no earnings base period quarters, with or without earnings in the fourth quarter, the fourth quarter remains in the base period and the department will exclude and substitute only three quarters in the base period.

b. Disqualifications. The request for retroactive substitution of base period quarters shall be denied if the individual received workers' compensation or indemnity insurance benefits in:

(1) At least three base period quarters but the individual is currently monetarily eligible with an established weekly and maximum benefit amount.

(2) At least three base period quarters and the individual has base period wages in three or more of the base period quarters, but the claim lacks qualifying earnings.

(3) Less than three base period quarters.

24.7(5) The individual shall be requested to complete the Affidavit and Questionnaire, Form 60-0286, which requests the following information:

a. Individual's name and social security number.

b. Name of employer responsible for the workers' compensation benefits or the indemnity insurance benefits.

c. Names of employers and periods worked for the period preceding the workers' compensation or the indemnity insurance pay period.

d. Name of the workers' compensation or indemnity insurance carrier or, if self-insured, the name of the employer.

e. Specify whether the wages determined to be in the individual's base period were or were not received for working in insured work during the base period.

24.7(6) The department will mail the redetermined initial claim to the individual. When the claim for benefits is determined to be monetarily eligible for payment, the employer responsible for the workers' compensation or the indemnity insurance benefits shall be notified of the redetermination and shall be responsible for the charges on the redetermined claim which are solely due to wage credits considered to be in the individual's base period due to the exclusion and substitution of calendar quarters. The employer responsible for the workers' compensation or indemnity insurance benefits shall have the right to protest as provided in rule 24.8(96).

871—24.8(96) Notifying employing units of claims filed, requests for wage and separation information, and decisions made.

24.8(1) Mailing of a notice of the filing of an initial claim or a request for wage and separation information to employing units.

a. The Form 65-5317, Notice of Claim, and the Form 68-0221, Request for Wage and Separation Information, shall be addressed to:

(1) The address or addresses as requested by the employing unit and agreed to by the department; or

(2) The business office of the employing unit where the records of the individual's employment are maintained; or

(3) The employing unit's place of business where the individual claiming benefits was most recently employed.

b. A notice of the filing of an initial claim or a request for wage and separation information shall be mailed to an owner, partner, executive officer, departmental manager or other responsible employee of the employing unit or to an agent designated to represent the employing unit in unemployment insurance matters.

(1) An agent who has been authorized to represent an employing unit in unemployment insurance matters may be furnished information from the files of the department to the extent designated in the authorization and in the same manner and to the same extent that the information would be furnished to the employing unit.

(2) The appointment of an agent to act for the employing unit and to receive documents and reports in no way abrogates the right of department representatives to deal directly with the employing unit when it appears that this will best serve the interest of the parties.

24.8(2) Responding by employing units to a notice of the filing of an initial claim or a request for wage and separation information and protesting the payment of benefits.

a. The employing unit which receives a Form 65-5317, Notice of Claim, or a Form 68-0221, Request for Wage and Separation Information, must, within ten days of the date of the notice or request, submit to the department wage or separation information that affects the individual's rights to benefits, including any facts which disclose that the individual separated from employment voluntarily and without good cause attributable to the employer or was discharged for misconduct in connection with employment.

b. The employing unit may protest the payment of benefits if the protest is postmarked within ten days of the date of the notice of the filing of an initial claim. In the event that the tenth day falls on a

Saturday, Sunday or holiday, the protest period is extended to the next working day of the department. If the employing unit has filed a timely report of facts that might adversely affect the individual's benefit rights, the report shall be considered as a protest to the payment of benefits.

c. If the employing unit protests that the individual was not an employee and it is subsequently determined that the individual's name was changed, the employing unit shall be deemed to have not been properly notified and the employing unit shall again be provided the opportunity to respond to the notice of the filing of the initial claim.

d. The employing unit has the option of notifying the department under conditions which, in the opinion of the employing unit, may disqualify an individual from receiving benefits. The notification may be made by mail using Form 60-0154, Notice of Separation, or by telephone using a telephone number designated by the department.

(1) The Notice of Separation, Form 60-0154, must be postmarked or received before or within ten days of the date that the Notice of Claim, Form 65-5317, was mailed to the employer. In the event that the tenth day falls on Saturday, Sunday or holiday, the protest period is extended to the next working day of the department. If a claim for unemployment insurance benefits has not been filed, the Notice of Separation may be accepted at any time.

(2) Rescinded IAB 2/10/99, effective 3/17/99.

24.8(3) Completing and signing of forms by an employing unit which may affect the benefit rights of an individual.

a. A notice of separation, and any response by an employing unit or its authorized agent to a notice of the filing of an initial claim or a request for wage and separation information, shall be accomplished by properly completing the form or computerized format provided by the department.

b. A notice of separation, and any paper response by an employing unit or its authorized agent to a notice of the filing of an initial claim or a request for wage and separation information, shall be executed by the employing unit on the form provided by the department under the signature of an individual proprietor, a partner, an executive officer, a department manager or other responsible employee who handles employee information, or who has direct knowledge of the reasons for the individual's separation from employment or by completing the computerized form designated by the department.

c. Failure by an employing unit or its authorized agent to properly complete or sign any form provided by the department relating to the adjudication of a claim shall result in the return of the form to the employing unit or its authorized agent for proper completion or signature; however, an extension of any notice or response period to allow for the return of the form shall not be granted.

d. Failure by an employing unit or its authorized agent to timely submit any notice or response requested by the department shall result in the department representative's making a determination of the individual's rights to benefits based on the information available.

24.8(4) Mailing of determinations, redeterminations and decisions to employing units.

a. An employing unit which has filed a timely response or protest to the notice of the filing of an initial claim shall be notified in writing of the determination as to the individual's rights to benefits. If an employing unit of the individual has submitted timely information affecting the individual's rights to benefits, including facts which disclose that the individual voluntarily quit without good cause attributable to the employing unit or was discharged for misconduct in connection with employment, the employing unit shall be notified in writing of the department's decision as to the cause of termination of the individual's employment.

b. Any notice of determination or decision shall contain a statement setting forth the employing unit's right of appeal.

c. Determinations as to an individual's right to benefits, decisions as to the cause of termination of the individual's employment, decisions as to an employing unit's experience record and correspondence related thereto shall be sent to:

(1) The address of the employing unit to which the notice of the filing of an initial claim was mailed; or

(2) The address requested by the employing unit on the document filed with the department in response or protest to the notice of the filing of an initial claim;

(3) If the employing unit in its response or protest to the notice of the filing of an initial claim furnishes the address of an agent for the employing unit and requests that further documents and correspondence be sent to the agent, the department representative shall comply, provided there is on file with the department an approved authorization (power of attorney) designating the agent to represent the employing unit.

871—24.9(96) Determination of benefit rights.

24.9(1) *Monetary determinations.*

a. When an initial claim for benefits is filed, the department shall mail to the individual claiming benefits a Form 65-5318, Iowa Monetary Record, which is a statement of the individual's weekly benefit amount, total benefits, base period wages, and other data pertinent to the individual's benefit rights.

b. The monetary record shall constitute a final decision unless newly discovered facts which affect the validity of the original determination or a written request for reconsideration is filed by the individual within ten days of the date of the mailing of the monetary record specifying the grounds of objection to the monetary record.

c. If newly discovered facts are obtained by the department or a written request for reconsideration is filed by the individual and is timely, an unemployment insurance representative shall examine the facts or the written request for reconsideration and shall promptly issue a redetermination or transfer the written request to an administrative law judge. The redetermination of the monetary record shall constitute a final decision unless a written appeal to an administrative law judge is filed by the individual within ten days of the date of the mailing of the redetermination specifying the grounds of objection to the redetermined monetary record. For the purposes of this paragraph, if the newly discovered facts obtained by the department would result in a change of the individual's maximum benefit amount of $25 or less, the department representative is not required to issue a redetermination unless a redetermination is requested by the individual, the employer, or a representative of another state or federal agency responsible for the administration of an unemployment insurance law.

d. For the purposes of this subrule, the appeal period is extended to the next working day of the department in the event that the tenth day falls on a Saturday, Sunday, or holiday. Also, failure of an individual to properly complete and sign any document relating to the adjudication of a claim shall result in the return of the document to the individual for proper completion or signature; however, an extension of the appeal period to allow for the return of the documents shall not be granted.

24.9(2) *Nonmonetary determinations.*

a. When a protest of an initial claim for benefits is filed, the department shall mail to the individual claiming benefits, and the most recent or any other base period employing unit, either a Form 60-0186 (manually generated) or a Form 65-5323 (computer generated), Unemployment Insurance Decision, which affects the individual's right to benefits.

b. The interested parties shall be afforded the opportunity to present facts and evidence in person or by telephone at an informational fact-finding interview scheduled by the department. An interested party, at the party's expense and with the party's equipment, may tape (video or audio) the proceedings. All participants must be informed of the taping of the interview. The taping of the interview must not be disruptive or distracting in nature.

c. Each of these decisions of the unemployment insurance representative shall constitute a final decision unless there are newly discovered facts which affect the validity of the original decision or a written request for reconsideration is filed by the individual, or the most recent or any other base period employing unit, within ten days of the date of the mailing of the decision specifying the grounds of objection to the decision.

d. If newly discovered facts are obtained by the department or a written request for reconsideration is timely filed by the individual, or the most recent or any other base period employing unit, an unemployment insurance representative shall examine the newly discovered facts or the written request for reconsideration and shall promptly issue a redetermination or transfer the written request to an administrative law judge. The redetermination of the decision shall constitute a final decision unless a written appeal to an administrative law judge is filed by the individual, or the most recent or any other

base period employing unit, within ten days of the date of the mailing of the redetermination specifying the grounds for objection to the redetermined decision.

e. For the purposes of this subrule, the protest period is extended to the next working day of the department in the event that the tenth day falls on a Saturday, Sunday or holiday. Also, failure by an individual or an employing unit to properly complete or sign any document relating to the adjudication of a claim shall result in the return of the document to the individual or employing unit for proper completion or signature; however, an extension of the protest period to allow for the return of the document shall not be granted.

871—24.10(96) Employer and employer representative participation in fact-finding interviews.

24.10(1) "Participate," as the term is used for employers in the context of the initial determination to award benefits pursuant to Iowa Code section 96.6, subsection 2, means submitting detailed factual information of the quantity and quality that if unrebutted would be sufficient to result in a decision favorable to the employer. The most effective means to participate is to provide live testimony at the interview from a witness with firsthand knowledge of the events leading to the separation. If no live testimony is provided, the employer must provide the name and telephone number of an employee with firsthand information who may be contacted, if necessary, for rebuttal. A party may also participate by providing detailed written statements or documents that provide detailed factual information of the events leading to separation. At a minimum, the information provided by the employer or the employer's representative must identify the dates and particular circumstances of the incident or incidents, including, in the case of discharge, the act or omissions of the claimant or, in the event of a voluntary separation, the stated reason for the quit. The specific rule or policy must be submitted if the claimant was discharged for violating such rule or policy. In the case of discharge for attendance violations, the information must include the circumstances of all incidents the employer or the employer's representative contends meet the definition of unexcused absences as set forth in 871—subrule 24.32(7). On the other hand, written or oral statements or general conclusions without supporting detailed factual information and information submitted after the fact-finding decision has been issued are not considered participation within the meaning of the statute.

24.10(2) "A continuous pattern of nonparticipation in the initial determination to award benefits," pursuant to Iowa Code section 96.6, subsection 2, as the term is used for an entity representing employers, means on 25 or more occasions in a calendar quarter beginning with the first calendar quarter of 2009, the entity files appeals after failing to participate. Appeals filed but withdrawn before the day of the contested case hearing will not be considered in determining if a continuous pattern of nonparticipation exists. The division administrator shall notify the employer's representative in writing after each such appeal.

24.10(3) If the division administrator finds that an entity representing employers as defined in Iowa Code section 96.6, subsection 2, has engaged in a continuous pattern of nonparticipation, the division administrator shall suspend said representative for a period of up to six months on the first occasion, up to one year on the second occasion and up to ten years on the third or subsequent occasion. Suspension by the division administrator constitutes final agency action and may be appealed pursuant to Iowa Code section 17A.19.

24.10(4) "Fraud or willful misrepresentation by the individual," as the term is used for claimants in the context of the initial determination to award benefits pursuant to Iowa Code section 96.6, subsection 2, means providing knowingly false statements or knowingly false denials of material facts for the purpose of obtaining unemployment insurance benefits. Statements or denials may be either oral or written by the claimant. Inadvertent misstatements or mistakes made in good faith are not considered fraud or willful misrepresentation.

This rule is intended to implement Iowa Code section 96.3(7)"b" as amended by 2008 Iowa Acts, Senate File 2160.

871—24.11(96) Eligibility review program.

24.11(1) *Purpose.* The eligibility review program is used to accelerate the individual's return to work and systematically review the individual's efforts toward the same goal.

24.11(2) *Individuals requiring an eligibility review.*

a. Selected individuals claiming intrastate benefits and interstate benefits shall be required to complete the eligibility review Form 60-0232 at times determined by the department after they have filed an initial or additional claim.

b. Rescinded IAB 8/6/03, effective 9/10/03.

24.11(3) *Eligibility review form.* Form 60-0232 contains information relating to eligibility and availability furnished by and to the individual, instructions and advice on reemployment that is given to the individual and the results of the individual's job search efforts.

a. The Eligibility Review Form 60-0232 encourages individuals to record information that bears directly on reemployment prospects and continued eligibility data.

b. It should conserve benefit funds through early identification of individuals who are restricting their availability.

c. It assures that job-ready individuals receive maximum exposure to available jobs by a workforce development center.

24.11(4) *Eligibility review procedure.*

a. After an individual has claimed a number of weeks of intrastate benefits as designated by the department, the workforce development center shall receive a computer selected list of individuals claiming benefits. The list shall be retained in the workforce development center so work search assistance and reemployment services can be provided as needed by the claimant.

b. No eligibility review will be performed on an individual unless monetary and nonmonetary eligibility are established.

c. An Eligibility Review Questionnaire shall be mailed or provided to the individual.

d. A copy of the Eligibility Review Questionnaire shall be sent to the workforce development center only on an individual who is in an active status at the time of its printing. If the individual fails to respond to the Eligibility Review Questionnaire within the designated period of time printed on the questionnaire, the workforce development center shall issue a Form 60-0131, Notice to Report. If the individual does not respond after this action has been taken, the department must issue an appropriate failure to report decision and lock the claim to prevent payment.

e. In cases of illness, injury or pregnancy, an unemployment insurance representative shall determine when and if a personal appearance shall be conducted. The representative shall be responsible for determining continuing eligibility or noneligibility of the individual based on the information obtained on the Form 60-0141, Request for Medical Report, or the facts presented during the interview. If the representative believes an additional Form 60-0141 may be needed, the representative shall initiate the request in the regular manner. Special attention shall be given to work search, i.e., number of contacts, types of contacts and the available job market information.

f. Before an administrative law judge can rule on a disqualification for failure to report at an Iowa workforce development center as directed, there must be evidence to show that the individual was required to report for an interview.

g. Rescinded IAB 8/6/03, effective 9/10/03.

24.11(5) *Scheduling first eligibility review interview.* Individuals shall be scheduled for an eligibility review interview if:

They are in demand occupations and still unemployed; it appears that they need help in finding work or their eligibility is suspect.

24.11(6) *Eligibility Review Form 60-0232.*

a. The Eligibility Review Form shall be completed by the individual. This form documents the information provided by the individual. The unemployment insurance representative reviews the information to determine if there are any disqualifying issues that need to be reviewed by conducting an interview in the local office or by telephone. If the interview is conducted by telephone, the individual may waive the opportunity for an in-person interview. The form also contains the individual's work

search plan and the unemployment insurance representative's advice and instruction to the individual concerning eligibility requirements and work search plans.

b. Rescinded IAB 8/6/03, effective 9/10/03.

24.11(7) *Conducting the first eligibility review interview.*

a. All available evidence must be examined to detect potentially disqualifying issues.

b. The individual's need for advice, assistance or instructions must be determined and conveyed to the individual.

c. The interview as recorded on the form must convey to the individual the requirements that must be satisfied to maintain eligibility insofar as work search and availability are concerned.

d. This advice, assistance or instruction constitutes an understanding and agreement between the individual and the unemployment insurance representative at the conclusion of the interview regarding the individual's willingness and ability to eliminate any barriers to obtaining reemployment which otherwise would result in referral for adjudication.

e. The individual shall be advised of what constitutes an acceptable effort to obtain reemployment in accordance with state policy considering local labor market information and the individual's occupation.

f. The final objective of the interview is to determine whether a subsequent interview is needed. This shall be based on expected return to work date, job openings in area, local labor market conditions, etc.

24.11(8) *Eligibility Review Statistics, Form 68-0150.* Rescinded IAB 8/6/03, effective 9/10/03.

This rule is intended to implement Iowa Code sections 96.4(3) and 96.6(1).

871—24.12 Reserved.

871—24.13(96) Deductible and nondeductible payments.

24.13(1) *Procedures for deducting payments from benefits.* Any payment defined under subrules 24.13(2) and 24.13(3) made to an individual claiming benefits shall be deducted from benefits in accordance with the following procedures until the amount is exhausted; however, vacation pay which is deductible in the manner prescribed in rule 24.16(96) shall be deducted first when paid in conjunction with other deductible payments described in this rule unless otherwise designated by the employer: The individual claiming benefits is required to designate the last day paid which may indicate payments made under this rule. The employer is required to designate on the Form 65-5317, Notice of Claim, the amount of the payment and the period to which the amount applies. If the individual or the employer does not designate the period to which the amount of the payment applies, and the unemployment insurance representative cannot otherwise determine the period, the unemployment insurance representative shall determine the week or weeks following the effective date of the claim to which the amount of the payment applies by dividing the amount of the payment by the individual's average weekly wage during the highest earnings quarter of the individual's base period. The amount of any payment under subrule 24.13(2) shall be deducted from the individual's weekly benefit amount on the basis of the formula used to compute an individual's weekly benefit payment as provided in rule 24.18(96). The amount of any payment under subrule 24.13(3) shall be fully deducted from the individual's weekly benefit amount on a dollar-for-dollar basis.

24.13(2) *Deductible payments from benefits.* The following payments are considered as wages and are deductible from benefits on the basis of the formula used to compute an individual's weekly benefit payment as provided in rule 24.18(96):

a. Holiday pay. However, if the actual entitlement to the holiday pay is subsequently not paid by the employer, the individual may request an underpayment adjustment from the department.

b. Commissions. However, the commission payment is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

c. Incentive pay. However, the incentive payment is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

d. *Strike pay.* However, the strike pay is only deductible when it is a payment received for services rendered and the individual is otherwise eligible for benefits.

e. *Remuneration other than cash.* The cash value of all remuneration payable in any medium other than cash, board, rent, housing, lodging, meals, or similar advantage, is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

f. *Stand-by pay.* When an individual is paid to hold oneself in readiness for a call to specific work for an employer but is not called, since the work is given to another, the payment is stand-by pay which is deductible from benefits when earned by the individual during the period when the individual is claiming benefits.

g. *Tips or gratuity.* However, the amount of the tips or gratuity is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

24.13(3) *Fully deductible payments from benefits.* The following payments are considered as wages; however, such payments are fully deductible from benefits on a dollar-for-dollar basis:

a. Wage interruption insurance payment. Any insurance payment received or due from wage interruption insurance because of fire, disaster, etc.

b. Excused personal leave. Excused personal leave, also referred to as casual pay or random pay, is personal leave with pay granted to an employee for absence from the job because of personal reasons. It shall be fully deductible only when taken in conjunction with a scheduled period of vacation in which case it shall be treated as vacation and be fully deductible in the manner prescribed in rule 24.16(96).

c. Wages in lieu of notice, separation allowance, severance pay and dismissal pay.

d. Workers' compensation, temporary disability only. The payment shall be fully deductible with respect to the week in which the individual is entitled to the workers' compensation for temporary disability, and not to the week in which such payment is paid.

e. Pension, retirement, annuity, or any other similar periodic payment made under a plan maintained and contributed to by a base period or chargeable employer. An individual's weekly benefit amount shall only be reduced by that portion of the payment which is the same percentage as the percentage contribution of the base period or chargeable employer to the plan.

24.13(4) *Nondeductible payments from benefits.* The following payments are not considered as wages and are not deductible from benefits:

a. Self-employment income. However, the individual must meet the benefit eligibility requirements of Iowa Code section 96.4(3).

b. Bonuses. The bonus payment is only nondeductible when based on service performed by the individual before the period in which the individual is also claiming benefits.

c. Remuneration for work performed by the individual claiming benefits in exchange for county relief in the form of groceries, rent, etc.

d. Payment for unused sick leave.

e. National guard duty pay. This includes reserve unit drill pay for any branch of the armed service.

f. Supplemental unemployment benefit plans approved by the department. See 871—subrule 23.3(1), paragraph *"e,"* for criteria and employer procedure for obtaining department approval.

g. Pension to the blind.

h. Payment for terminal leave. Any payment received by military personnel for unused leave upon discharge.

i. Compensation for military service-connected disability from the Department of Veterans Affairs.

j. Payments to the surviving spouse of a regular or disability pension based on the work of the deceased spouse.

k. Deferred wage compensation. Remuneration received by the individual for wages earned in a period prior to the individual's claim for benefits shall not be deductible during the period in which the individual is claiming benefits.

l. Witness and jury fees. These fees are reimbursement for expenses and are not considered as wages.

m. Supplemental security income. This payment is nondeductible because it is financed by income taxes and not social security taxes and is based on need factors such as age, mental or physical disability, and personal income, and not on previous employment.

n. Federal social security benefit and social security disability payments.

This rule is intended to implement Iowa Code sections 96.3(3), 96.5, 96.5(5), 96.11(1), and 96.19(38).

871—24.14 and **24.15** Reserved.

871—24.16(96) Vacation pay.

24.16(1) If the employer properly notifies the department within ten days after the notification of the filing of the claim that an amount of vacation pay, either paid or owed, is to be applied to a specific vacation period, a sum equal to the wages of the individual for a normal workday shall be applied to the first and each subsequent workday of the designated vacation period until the amount of the vacation pay is exhausted.

24.16(2) If the employer makes the original designation of the vacation period in a timely manner, the employer may extend the vacation period by designating the period of the extension in writing to the department before the period of extension begins.

24.16(3) If the employer fails to properly notify the department within ten days after the notification of the filing of the claim that an amount of vacation pay, either paid or owed, is to be applied to a specific vacation period, the entire amount of the vacation pay shall be applied to the one-week period starting on the first workday following the last day worked as defined in subrule 24.16(4). However, if the individual does not claim benefits after layoff during the normal employer workweek immediately following the last day worked, then the entire amount of the vacation pay shall not be deducted from any week of benefits.

24.16(4) Unless otherwise specified by the employer, the amount of the vacation pay shall be converted by the department to eight hours for a normal workday and five workdays for a normal workweek.

This rule is intended to implement Iowa Code section 96.5(7).

871—24.17(96) Vacation pay procedure.

24.17(1) Employer notice specified vacation or holiday pay only. The Form 65-5317, Notice of Claim, the Form 62-2048, Request for Federal Wage and Separation Information, and the Form 62-2049, Request for Wage and Separation Information on Federal Employment Additional Claim, which are returned by the employer for the purpose of notification of vacation pay, shall be used as notification to the department that vacation pay is applicable. The Forms 65-5317, 62-2048, and the 62-2049 received in the administrative office shall be routed to the appropriate office for the following action:

a. Upon receipt of the vacation information, the unemployment insurance representative shall immediately issue the appropriate decision concerning the vacation pay to the employer and to the claimant. The unemployment insurance representative shall then check the current status of the claim on the computer record to ascertain if any weeks have been reported.

b. The representative shall compare the amount of vacation reported by the employer with the computer record. If the computer record shows any discrepancies, the representative shall initiate immediate action to set up an overpayment or underpayment as appropriate.

c. If the computer record shows that the claimant has not reported or claimed for some or all of the weeks indicated for the vacation period, the unemployment insurance representative shall take no further action on the weeks not claimed.

d. The claimant shall be instructed to only report vacation pay applicable to the first week. The claimant shall also be instructed that vacation pay designated by the employer in excess of one week may result in an overpayment of benefits.

24.17(2) Reserved.

This rule is intended to implement Iowa Code section 96.5(7).

871—24.18(96) Wage-earnings limitation. An individual who is partially unemployed may earn weekly a sum equal to the individual's weekly benefit amount plus $15 before being disqualified for excessive earnings. If such individual earns less than the individual's weekly benefit amount plus $15, the formula for wage deduction shall be a sum equal to the individual's weekly benefit amount less that part of wages, payable to the individual with respect to that week and rounded to the nearest dollar, in excess of one-fourth of the individual's weekly benefit amount.

This rule is intended to implement Iowa Code sections 96.3, 96.4 and 96.19(38).

871—24.19(96) Determination and review of benefit rights.

24.19(1) Claims for benefits shall be promptly determined by the department on the basis of such facts as it may obtain. Notice of such determination shall be promptly given to each claimant and to any employer whose employment relationship with the claimant, or the claimant's separation therefrom, involves actual or potential disqualifying issues relevant to the determination. Such notice to the claimant shall advise of the weekly benefit amount, duration of benefits, wage records, other data pertinent to benefit rights, and if disqualified, the time of and reason for such disqualification. If a claimant is ineligible, such claimant shall be advised of such ineligibility and the reason therefor. Each notice of benefit determination which the department is required to furnish to the claimant shall, in addition to stating the decision and its reasons, include a notice specifying the claimant's appeal rights. The notice of appeal rights shall state clearly the place and manner for taking an appeal from the determination and the period within which an appeal may be taken. Unless the claimant or any such other party entitled to notice, within ten days after such notification was mailed to such claimant's last-known address, files with the department a written request for a review of or an appeal from such determination, such determination shall be final.

24.19(2) Each interested party will be afforded the opportunity to have an in-person fact-finding interview regarding matters which are scheduled for a hearing. However, when it is impractical for the department to conduct an in-person fact-finding, the fact-finding may be conducted in whole or in part by telephone at the discretion of the department. The department shall reserve the right to call any interested party in for an in-person fact-finding interview.

24.19(3) Upon receiving a written request for review or, on its own initiative and on the basis of the facts as it may have in its possession or may acquire, the claims section may affirm, modify, or reverse the prior decision, or refer the claim to an administrative law judge. The claimant or any other party filing the request for review shall be promptly notified of the decision or referral. Unless the claimant or any other party files an appeal within ten days after the date of mailing, the latter decision shall be final and benefits shall be paid or denied in accordance therewith.

871—24.20 and **24.21** Reserved.

871—24.22(96) Benefit eligibility conditions. For an individual to be eligible to receive benefits the department must find that the individual is able to work, available for work, and earnestly and actively seeking work. The individual bears the burden of establishing that the individual is able to work, available for work, and earnestly and actively seeking work.

24.22(1) *Able to work.* An individual must be physically and mentally able to work in some gainful employment, not necessarily in the individual's customary occupation, but which is engaged in by others as a means of livelihood.

a. Illness, injury or pregnancy. Each case is decided upon an individual basis, recognizing that various work opportunities present different physical requirements. A statement from a medical practitioner is considered prima facie evidence of the physical ability of the individual to perform the work required. A pregnant individual must meet the same criteria for determining ableness as do all other individuals.

b. Interpretation of ability to work. The law provides that an individual must be able to work to be eligible for benefits. This means that the individual must be physically able to work, not necessarily in the individual's customary occupation, but able to work in some reasonably suitable, comparable,

gainful, full-time endeavor, other than self-employment, which is generally available in the labor market in which the individual resides.

24.22(2) *Available for work.* The availability requirement is satisfied when an individual is willing, able, and ready to accept suitable work which the individual does not have good cause to refuse, that is, the individual is genuinely attached to the labor market. Since, under unemployment insurance laws, it is the availability of an individual that is required to be tested, the labor market must be described in terms of the individual. A labor market for an individual means a market for the type of service which the individual offers in the geographical area in which the individual offers the service. Market in that sense does not mean that job vacancies must exist; the purpose of unemployment insurance is to compensate for lack of job vacancies. It means only that the type of services which an individual is offering is generally performed in the geographical area in which the individual is offering the services.

a. Shift restriction. The individual does not have to be available for a particular shift. If an individual is available for work on the same basis on which the individual's wage credits were earned and if after considering the restrictions as to hours of work, etc., imposed by the individual there exists a reasonable expectation of securing employment, then the individual meets the requirement of being available for work.

b. Job test. The best method of testing availability for work is an offer of work or job test. If a job test is not possible because of lack of a suitable offer, the active search for work is relied on and conclusions are likely to be based entirely on the fact that the individual did or did not make a search, without regard to the fact that the individual's personal efforts had little probability of success.

c. Intermittent employment. An individual cannot restrict employability to only temporary or intermittent work until recalled by a regular employer.

d. Jury duty. The individual is considered available for work while serving on jury duty because time spent in jury service is not a personal service performed under a contract of hire in an employment situation but is a public duty required by law. Jury duty does not render the individual as employed and ineligible for benefits even though it may involve the individual full-time. Witness and jury fees will be considered as reimbursement for expenses and not as wages.

e. Company employment office. The department is not bound by a union/company contract that requires the individual to report at the company employment office. The individual is an independent agent seeking work, and may be found available, if an otherwise diligent search of work is made.

f. Part-time worker, student—other. Part-time worker shall mean any individual who has been in the employ of an employing unit and has established a pattern of part-time regular employment which is subject to the employment security tax, and has accrued wage credits while working in a part-time job. If such part-time worker becomes separated from this employment for no disqualifiable reason, and providing such worker has reasonable expectation of securing other employment for the same number of hours worked, no disqualification shall be imposed under Iowa Code section 96.4(3). In other words, if an individual is available to the same degree and to the same extent as when the wage credits were accrued, the individual meets the eligibility requirements of the law.

g. Work release program while incarcerated. For those individuals incarcerated in jail, the work release program usually does not meet the availability requirements of Iowa Code section 96.4(3); but the department will review any situation concerning an individual incarcerated in a jail, who can meet the able to work, availability for work, and actively seeking work requirements of Iowa Code section 96.4(3).

h. Available for part of week. Each case must be decided on its own merits. Generally, if the individual is available for the major portion of the workweek, the individual is considered to be available for work.

i. On-call workers.

(1) Substitute workers (i.e., post office clerks, railroad extra board workers), who hold themselves available for one employer and who do not accept other work, are not available for work within the meaning of the law and are not eligible for benefits.

(2) Substitute teachers. The question of eligibility of substitute teachers is subjective in nature and must be determined on an individual case basis. The substitute teacher is considered an instructional

employee and is subject to the same limitations as other instructional employees. As far as payment of benefits between contracts or terms and during customary and established periods of holiday recesses is concerned, benefits are denied if the substitute teacher has a contract or reasonable assurance that the substitute teacher will perform service in the period immediately following the vacation or holiday recess. An on-call worker (includes a substitute teacher) is not disqualified if the individual is able and available for work, making an earnest and active search for work each week, placing no restrictions on employment and is genuinely attached to the labor market.

(3) An individual whose wage credits earned in the base period of the claim consist exclusively of wage credits by performing on-call work, such as a banquet worker, railway worker, substitute school teacher or any other individual whose work is solely on-call work during the base period, is not considered an unemployed individual within the meaning of Iowa Code section 96.19(38)*"a"* and *"b."* An individual who is willing to accept only on-call work is not considered to be available for work.

j. Leave of absence. A leave of absence negotiated with the consent of both parties, employer and employee, is deemed a period of voluntary unemployment for the employee-individual, and the individual is considered ineligible for benefits for the period.

(1) If at the end of a period or term of negotiated leave of absence the employer fails to reemploy the employee-individual, the individual is considered laid off and eligible for benefits.

(2) If the employee-individual fails to return at the end of the leave of absence and subsequently becomes unemployed the individual is considered as having voluntarily quit and therefore is ineligible for benefits.

(3) The period or term of a leave of absence may be extended, but only if there is evidence that both parties have voluntarily agreed.

k. Effect of religious convictions on Sabbath day work. An individual is considered as available for work if the precepts of the individual's religion prohibit work on the Sabbath. An individual who refuses to work on the Sabbath designated by the individual's religion, because of conscientious observance of the Sabbath as a matter of religious conviction, is also deemed to have good cause for refusing the work.

l. Available for work. To be considered available for work, an individual must at all times be in a position to accept suitable employment during periods when the work is normally performed. As an individual's length of unemployment increases and the individual has been unable to find work in the individual's customary occupation, the individual may be required to seek work in some other occupation in which job openings exist, or if that does not seem likely to result in employment, the individual may be required to accept counseling for possible retraining or a change in occupation.

m. Restrictions and reasonable expectation of securing employment. An individual may not be eligible for benefits if the individual has imposed restrictions which leave the individual no reasonable expectation of securing employment. Restrictions may relate to type of work, hours, wages, location of work, etc., or may be physical restrictions.

n. Corporate officers. To be considered available, the corporation officer must meet the same tests of availability as are met by other individuals. The individual must be desirous of other work, be free from serious limitations and be seriously searching for work. The reported efforts of a corporate officer to seek work should be studied to distinguish those directed toward obtaining work for the officer as an individual and those directed to obtaining work or business for the corporation. Any effort to obtain business for the corporation to perform is a service to the corporation and is not evidence of the individual's own availability for work.

o. Lawfully authorized work. An individual who is not lawfully authorized to work within the United States will be considered not available for work.

24.22(3) *Earnestly and actively seeking work.* Mere registration at a workforce development center does not establish that the individual is earnestly and actively seeking work. It is essential that the individual personally and diligently search for work. It is difficult to establish definite criteria for defining the words earnestly and actively. Much depends on the estimate of the employment opportunities in the area. The number of employer contacts which might be appropriate in an area of limited opportunity might be totally unacceptable in other areas. When employment opportunities are high an individual may be expected to make more than the usual number of contacts. Unreasonable limitations by an individual

as to salary, hours or conditions of work can indicate that the individual is not earnestly seeking work. The department expects each individual claiming benefits to conduct themselves as would any normal, prudent individual who is out of work.

a. Basic requirements. An individual shall be ineligible for benefits for any period for which the department finds that the individual has failed to make an earnest and active search for work. The circumstances in each case are considered in determining whether an earnest and active search for work has been made. Subject to the foregoing, applicable actions of the following kind are considered an earnest and active search for work if found by the department to constitute a reasonable means of securing work by the individual, under the facts and circumstances of the individual's particular situation:

(1) Making application with employers as may reasonably be expected to have openings suitable to the individual.

(2) Registering with a placement facility of a school, college, or university if one is available in the individual's occupation or profession.

(3) Making application or taking examination for openings in the civil service of a governmental entity with reasonable prospects of suitable work for the individual.

(4) Responding to appropriate "want ads" for work which appears suitable to the individual if the response is made in writing or in person or electronically.

(5) Any other action which the department finds to constitute an effective means of securing work suitable to the individual.

(6) No individual, however, is denied benefits solely on the ground that the individual has failed or refused to register with a private employment agency or at any other placement facility which charges the job-seeker a fee for its services. However, an individual may count as one of the work contacts required for the week an in-person contact with a private employment agency.

(7) An individual is considered to have failed to make an effort to secure work if the department finds that the individual has followed a course of action designed to discourage prospective employers from hiring the individual in suitable work.

b. Number of employer contacts. It is difficult to determine criteria in which earnestly and actively may be interpreted. Much depends on the estimate of employment opportunities in the area. The number of employer contacts which might be appropriate in an area of limited opportunities might be totally unacceptable in another area of unlimited opportunities. The number of contacts that an individual must make is dependent upon the condition of the local labor market, the duration of benefit payments, a change in the individual's characteristics, job prospects in the community, and other factors as the department deems necessary.

c. Union and professional employees. Members of unions or professional organizations who normally obtain their employment through union or professional organizations are considered as earnestly and actively seeking work if they maintain active contact with the union's business agent or with the placement officer in the professional organization. A paid-up membership must be maintained if this is a requirement for placement service. The trade, profession or union to which the individual belongs must have an active hiring hall or placement facility, and the trade, profession or union must be the source customarily used by employers in filling their job openings. Registering with the individual's union hiring or placement facility is sufficient except that whenever all benefit rights to regular benefits are exhausted and Iowa is in an extended benefit period or similar program such as the federal supplemental compensation program, individuals must also actively search for work; mere registration at a union or reporting to union hiring hall or registration with a placement facility of the individual's professional organization does not satisfy the extended benefit systematic and sustained effort to find work, and additional work contacts must be made.

d. Week-to-week disqualification. Active search for work disqualifications are to be made on a week-to-week basis and are not open-end disqualifications.

e. Seniority rights. An individual who fails to exercise seniority rights to replace another employee with less seniority has the work search requirement waived during a period of regular benefits. This waiver does not apply to the individual who is receiving extended benefits or similar federal program benefits.

f. Search for work.

(1) The Iowa law specifies that an individual must earnestly and actively seek work. This is interpreted to mean that a registration for work at a workforce development center or state employment service office in itself does not meet the requirements of the law. Nor is it interpreted to mean that every individual must make a fixed number of employer contacts each week to establish eligibility. The number of contacts that an individual must make is dependent upon the condition of the local labor market, the duration of benefit payments, a change in claimant characteristics, job prospects in the community, and such other factors as the department deems relevant.

(2) The individual is referred to suitable work, when possible, to those employers who have outstanding requests with the department of workforce development for referrals. The individual must meet the minimum lawful requirements of the employer. The individual applies to and obtains the signatures of the employer so designated on the form provided, unless the employer refuses to sign the form. The individual must return the form to the department as directed. The individual's failure to obtain the signature of designated employers, who have not refused to sign the form, disqualifies the individual from future benefits until requalified by earning ten times the weekly benefit amount.

(3) The group assignment of individuals is used, to a certain extent, in determining which ones are required to make personal applications for work. Other factors, however, such as the condition of the local labor market, the duration of benefit payments, and a change in claimant characteristics, are also taken into consideration on a weekly basis.

(4) Individuals receiving partial benefits are exempt from making personal applications for work, in any week they have worked and received wages from their regular employer. Individuals involved in hiring hall practices must keep in weekly touch with the business agent of that union in which they maintain membership. All other individuals must make contacts with such frequency as the department considers advisable, after considering job prospects in the community, the condition of the labor market and any other factors which may have a bearing on the individual's reemployment. A sincere effort must be made to find a job. A contact made merely for the sake of complying with the law is not good enough.

g. Reverse referral. A reverse referral is defined as an employer hiring only through the department of workforce development and all individuals applying for employment with the employer are referred to the department. An individual may use the department as work contacts during a week with the employer's name and the workforce development employee's name listed as the individual contacted. The workforce development center must be contacted in person by the individual to utilize each reverse referral registration job contact.

h. Job search assistance. Job search assistance classes, including reemployment services, which are sponsored by the department of workforce development and attended by the individual during a week may be counted as one of the individual's work search contacts for that week.

This rule is intended to implement Iowa Code section 96.4(3).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—24.23(96) Availability disqualifications. The following are reasons for a claimant being disqualified for being unavailable for work.

24.23(1) An individual who is ill and presently not able to perform work due to illness.

24.23(2) An individual presently in the hospital is deemed not to meet the availability requirements of Iowa Code section 96.4(3) and benefits will be denied until a change in status and the individual can meet the eligibility requirements. Such individual must renew the claim at once if unemployed.

24.23(3) If an individual places restrictions on employability as to the wages and type of work that is acceptable and when considering the length of unemployment, such individual has no reasonable expectancy of securing work, such individual will be deemed not to have met the availability requirements of Iowa Code section 96.4(3).

24.23(4) If the means of transportation by an individual was lost from the individual's residence to the area of the individual's usual employment, the individual will be deemed not to have met the availability requirements of the law. However, an individual shall not be disqualified for restricting employability to the area of usual employment. See subrule 24.24(7).

24.23(5) Full-time students devoting the major portion of their time and efforts to their studies are deemed to have no reasonable expectancy of securing employment except if the students are available to the same degree and to the same extent as they accrued wage credits they will meet the eligibility requirements of the law.

24.23(6) If an individual has a medical report on file submitted by a physician, stating such individual is not presently able to work.

24.23(7) Where an individual devotes time and effort to becoming self-employed.

24.23(8) Where availability for work is unduly limited because of not having made adequate arrangements for child care.

24.23(9) Reserved.

24.23(10) The claimant requested and was granted a leave of absence, such period is deemed to be a period of voluntary unemployment and shall be considered ineligible for benefits for such period.

24.23(11) Failure to report as directed to workforce development in response to the notice which was mailed to the claimant will result in the claimant being deemed not to meet the availability requirements.

24.23(12) If a claimant is in jail or prison, such claimant is not available for work.

24.23(13) Rescinded IAB 8/6/03, effective 9/10/03.

24.23(14) An individual is deemed not available for work because such individual cannot be contacted by the department for referral to possible employment.

24.23(15) Where a claimant has demanded a wage in excess of the wages most commonly paid in such claimant's locality for the suitable work the individual is seeking.

24.23(16) Where availability for work is unduly limited because a claimant is not willing to work during the hours in which suitable work for the claimant is available.

24.23(17) Work is unduly limited because the claimant is not willing to work the number of hours required to work in the claimant's occupation.

24.23(18) Where the claimant's availability for work is unduly limited because such claimant is willing to work only in a specific area although suitable work is available in other areas where the claimant is expected to be available for work.

24.23(19) Availability for work is unduly limited because the claimant is not willing to accept work in such claimant's usual occupation and has failed to establish what other types of work that can and will be performed at the wages most commonly paid in the claimant's locality.

24.23(20) Where availability for work is unduly limited because the claimant is waiting to be recalled to work by a former employer or waiting to go to work for a specific employer and will not consider suitable work with other employers.

24.23(21) Rescinded IAB 8/6/03, effective 9/10/03.

24.23(22) Where a claimant does not want to earn enough wages during the year to adversely affect receipt of federal old-age benefits (social security).

24.23(23) The claimant's availability for other work is unduly limited because such claimant is working to such a degree that removes the claimant from the labor market.

24.23(24) When a claimant is receiving from the Veterans Administration an educational assistance allowance under the War Orphans Educational Assistance Act of 1956, which is disqualifying under the Social Security Act.

24.23(25) If the claimant is out of town for personal reasons for the major portion of the workweek and is not in the labor market.

24.23(26) Where a claimant is still employed in a part-time job at the same hours and wages as contemplated in the original contract for hire and is not working on a reduced workweek basis different from the contract for hire, such claimant cannot be considered partially unemployed.

24.23(27) Failure to report on a claim that a claimant made any effort to find employment will make a claimant ineligible for benefits during the period. Mere registration at the workforce development center does not establish that a claimant is able and available for suitable work. It is essential that such claimant must actively and earnestly seek work.

24.23(28) A claimant will be ineligible for benefits because of failure to make an adequate work search after having been previously warned and instructed to expand the search for work effort.

24.23(29) Failure to work the major portion of the scheduled workweek for the claimant's regular employer.

24.23(30) Failure to attend the major portion of the scheduled workweek for department approved training.

24.23(31) Where the claimant spent the major portion of the period traveling while relocating.

24.23(32) The claimant is ineligible for benefits because no search for work was made during the period such claimant was on vacation unless the provisions of Iowa Code section 96.19(38)*"c"* are met.

24.23(33) Where the claimant left employment prior to a scheduled date of layoff when such claimant could have remained in employment during this period. No disqualification may be imposed in accordance with Iowa Code section 96.5(1)*"g"* for the period subsequent to the date of the scheduled layoff if such claimant is otherwise eligible. The claimant will be disqualified for the period between the last day worked and the date of the scheduled layoff because of voluntary unemployment.

24.23(34) Where the claimant is not able to work due to personal injury.

24.23(35) Where the claimant is not able to work and is under the care of a medical practitioner and has not been released as being able to work.

24.23(36) Rescinded IAB 8/6/03, effective 9/10/03.

24.23(37) An individual shall be deemed to have failed to make an effort to secure work if the individual has followed a course of action designed to discourage prospective employers from hiring such individual in suitable work.

24.23(38) Rescinded IAB 8/6/03, effective 9/10/03.

24.23(39) Where the work search or the Eligibility Review Form has been deliberately falsified for the purpose of obtaining unemployment insurance benefits. The general guide for disqualifications for falsification of work search is listed below. It is intended to be used as a guide only and is not a substitute for the personal subjective judgment of the representative because each case must be decided on its own merits. The administrative penalty recommended for falsification is:

a. First offense—six weeks penalty.

b. Second offense—nine weeks penalty.

c. Third offense—total disqualification for the remainder of the benefit year plus consideration of the possibility of filing fraud charges depending on the circumstances.

24.23(40) Reserved.

24.23(41) The claimant became temporarily unemployed, but was not available for work with the employer that temporarily laid the claimant off. The evidence must establish that the claimant had a choice to work, and that the willingness to work would have led to actual employment in suitable work during the weeks the employer temporarily suspended operations.

This rule is intended to implement Public Law 96-499, Iowa Code sections 96.4(3), 96.5(1), 96.6(1), 96.19(38)*"c"* and 96.29.

871—24.24(96) Failure to accept work and failure to apply for suitable work. Failure to accept work and failure to apply for suitable work shall be removed when the individual shall have worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

24.24(1) *Bona fide offer of work.*

a. In deciding whether or not a claimant failed to accept suitable work, or failed to apply for suitable work, it must first be established that a bona fide offer of work was made to the individual by personal contact or that a referral was offered to the claimant by personal contact to an actual job opening and a definite refusal was made by the individual. For purposes of a recall to work, a registered letter shall be deemed to be sufficient as a personal contact.

b. Upon notification of a job opening for a claimant, a representative of the department shall notify the claimant of the job referral. If the claimant fails to respond without good cause, the claimant shall be disqualified until such time as the claimant contacts the local workforce development center or unemployment insurance service center.

24.24(2) *Job within claimant's capabilities.*

a. The job offered must be within the claimant's physical capabilities and not require any undue physical skill or particular training which the claimant does not already possess. As the period of unemployment lengthens, work which might originally have been unsuitable may become suitable.

b. If the claimant, separated for lack of work, fails to accept work offered by the employer on recall or fails to apply for work when directed by a representative of the department, such failure shall constitute a refusal of suitable work. In such a situation said claimant shall be disqualified for failure to apply for or accept an offer to work until such time as the individual shall have worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

24.24(3) *Each case decided on its own merits.* Based upon the facts found by the department through investigation it shall then be determined whether the work was suitable and whether the claimant has good cause for refusal. Each case shall be determined on its own merits as established by the facts. A reason constituting good cause for refusal of suitable work may nevertheless disqualify such claimant as being not available for work.

24.24(4) *Work refused when the claimant fails to meet the benefit eligibility conditions of Iowa Code section 96.4(3).* Before a disqualification for failure to accept work may be imposed, an individual must first satisfy the benefit eligibility conditions of being able to work and available for work and not unemployed for failing to bump a fellow employee with less seniority. If the facts indicate that the claimant was or is not available for work, and this resulted in the failure to accept work or apply for work, such claimant shall not be disqualified for refusal since the claimant is not available for work. In such a case it is the availability of the claimant that is to be tested. Lack of transportation, illness or health conditions, illness in family, and child care problems are generally considered to be good cause for refusing work or refusing to apply for work. However, the claimant's availability would be the issue to be determined in these types of cases.

24.24(5) *Bumping rights to a job.* A claimant who fails to exercise seniority rights to bump a less senior employee is eligible for benefits and the provision pertaining to the search for work is waived during a period of regular unemployment insurance benefits. This waiver of the search for work does not apply to a claimant who is receiving extended benefits.

24.24(6) *Claimant physically unable to perform job.* A medical certification from a medical practitioner must be submitted to support the claimant's statement that work offered is not suitable because of the claimant's physical condition.

24.24(7) *Gainfully employed outside of area where job is offered.* Two reasons which generally would be good cause for not accepting an offer of work would be if the claimant were gainfully employed elsewhere or the claimant did not reside in the area where the job was offered.

24.24(8) *Refusal disqualification jurisdiction.* Both the offer of work or the order to apply for work and the claimant's accompanying refusal must occur within the individual's benefit year, as defined in subrule 24.1(21), before the Iowa Code subsection 96.5(3) disqualification can be imposed. It is not necessary that the offer, the order, or the refusal occur in a week in which the claimant filed a weekly claim for benefits before the disqualification can be imposed.

24.24(9) Reserved.

24.24(10) *Distance to new job.* Without a prior specific agreement between the employer and employee the employee's refusal to follow the employer to a distant new job site shall not be reason for a refusal disqualification.

24.24(11) *Bulletin board notice of work.* A bulletin board notice for employees to work during a plant shutdown shall not constitute an offer of work by the company. Such offer of work must be by personal contact to the employee.

24.24(12) *Claimant discourages prospective employers.* When a claimant willfully follows a course of action designed to discourage a prospective employer from hiring such claimant, the claimant shall be deemed to have refused suitable work as contemplated by the statute.

24.24(13) *Claimant moved to another state.* A claimant who moves to another state shall not be subject to disqualification for refusal to return to a previously held job.

24.24(14) *Employment offer from former employer.*

a. The claimant shall be disqualified for a refusal of work with a former employer if the work offered is reasonably suitable and comparable and is within the purview of the usual occupation of the claimant. The provisions of Iowa Code section 96.5(3)*"b"* are controlling in the determination of suitability of work.

b. The employment offer shall not be considered suitable if the claimant had previously quit the former employer and the conditions which caused the claimant to quit are still in existence.

24.24(15) *Suitable work.* In determining what constitutes suitable work, the department shall consider, among other relevant factors, the following:

a. Any risk to the health, safety and morals of the individual.

b. The individual's physical fitness.

c. Prior training.

d. Length of unemployment.

e. Prospects for securing local work by the individual.

f. The individual's customary occupation.

g. Distance from the available work.

h. Whether the work offered is for wages equal to or above the federal or state minimum wage, whichever is higher.

i. Whether the work offered meets the percentage criteria established for suitable work which is determined by the number of weeks which have elapsed following the effective date of the most recent new or additional claim for benefits filed by the individual.

j. Whether the position offered is due directly to a strike, lockout, or other labor dispute.

k. Whether the wages, hours or other conditions of employment are less favorable for similar work in the locality.

l. Whether the individual would be required to join or resign from a labor organization.

24.24(16) *Disabled accessibility to job.* A job offer shall not be suitable if a disabled individual has no access to a building or its facilities.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(2), 96.4(3), 96.5(1), 96.5(3), 96.6(1), 96.11(1), 96.16, 96.19(38), and 96.29.

871—24.25(96) Voluntary quit without good cause. In general, a voluntary quit means discontinuing the employment because the employee no longer desires to remain in the relationship of an employee with the employer from whom the employee has separated. The employer has the burden of proving that the claimant is disqualified for benefits pursuant to Iowa Code section 96.5. However, the claimant has the initial burden to produce evidence that the claimant is not disqualified for benefits in cases involving Iowa Code section 96.5, subsection (1), paragraphs *"a"* through *"i,"* and subsection 10. The following reasons for a voluntary quit shall be presumed to be without good cause attributable to the employer:

24.25(1) The claimant's lack of transportation to the work site unless the employer had agreed to furnish transportation.

24.25(2) The claimant moved to a different locality.

24.25(3) The claimant left to seek other employment but did not secure employment.

24.25(4) The claimant was absent for three days without giving notice to employer in violation of company rule.

24.25(5) Reserved.

24.25(6) The claimant left as a result of an inability to work with other employees.

24.25(7) The claimant failed to return to work upon the termination of a labor dispute.

24.25(8) The claimant left to enter military service, either voluntarily or by conscription. While in military service such claimant shall be considered to be on leave from employment. It shall only be considered a voluntary quit issue when upon release from military service such claimant does not return to such claimant's employer to apply for employment within 90 days; provided, that such person shall give evidence to the employer of satisfactory completion of such military service and further provided that such person is still qualified to perform the duties of such position.

24.25(9) Reserved.

24.25(10) The claimant left employment to accompany the spouse to a new locality.

24.25(11) The claimant left to get married.

24.25(12) The claimant left without notice during a mutually agreed upon trial period of employment.

24.25(13) The claimant left because of dissatisfaction with the wages but knew the rate of pay when hired.

24.25(14) Reserved.

24.25(15) Reserved.

24.25(16) The claimant is deemed to have left if such claimant becomes incarcerated.

24.25(17) The claimant left because of lack of child care.

24.25(18) The claimant left because of a dislike of the shift worked.

24.25(19) The claimant left to enter self-employment.

24.25(20) The claimant left for compelling personal reasons; however, the period of absence exceeded ten working days.

24.25(21) The claimant left because of dissatisfaction with the work environment.

24.25(22) The claimant left because of a personality conflict with the supervisor.

24.25(23) The claimant left voluntarily due to family responsibilities or serious family needs.

24.25(24) The claimant left employment to accept retirement when such claimant could have continued working.

24.25(25) The claimant left to take a vacation.

24.25(26) The claimant left to go to school.

24.25(27) The claimant left rather than perform the assigned work as instructed.

24.25(28) The claimant left after being reprimanded.

24.25(29) The claimant left in anticipation of a layoff in the near future; however, work was still available at the time claimant left the employment.

24.25(30) The claimant left due to the commuting distance to the job; however, the claimant was aware of the distance when hired.

24.25(31) The claimant left work to keep from earning enough wages during the year to adversely affect claimant's receipt of federal old-age benefits (social security).

24.25(32) The claimant left by refusing a transfer to another location when it was known at the time of hire that it was customary for employees to transfer as required by the job.

24.25(33) The claimant left because such claimant felt that the job performance was not to the satisfaction of the employer; provided, the employer had not requested the claimant to leave and continued work was available.

24.25(34) The claimant left because work was irregular due to weather conditions; however, this working condition was not unusual in claimant's type of employment.

24.25(35) The claimant left because of illness or injury which was not caused or aggravated by the employment or pregnancy and failed to:

a. Obtain the advice of a licensed and practicing physician;

b. Obtain certification of release for work from a licensed and practicing physician;

c. Return to the employer and offer services upon recovery and certification for work by a licensed and practicing physician; or

d. Fully recover so that the claimant could perform all of the duties of the job.

24.25(36) The claimant maintained that the claimant left due to an illness or injury which was caused or aggravated by the employment. The employer met its burden of proof in establishing that the illness or injury did not exist or was not caused or aggravated by the employment.

24.25(37) The claimant will be considered to have left employment voluntarily when such claimant gave the employer notice of an intention to resign and the employer accepted such resignation. This rule shall also apply to the claimant who was employed by an educational institution who has declined or refused to accept a new contract or reasonable assurance of work for a successive academic term or year and the offer of work was within the purview of the individual's training and experience.

24.25(38) Where the claimant gave the employer an advance notice of resignation which caused the employer to discharge the claimant prior to the proposed date of resignation, no disqualification shall be imposed from the last day of work until the proposed date of resignation; however, benefits will be denied effective the proposed date of resignation.

24.25(39) Reserved.

24.25(40) Where the claimant voluntarily quit in advance of the announced scheduled layoff, the disqualification period will be from the last day worked to the date of the scheduled layoff. Benefits shall not be denied from the effective date of the scheduled layoff.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(3), 96.4(5), 96.5(1), 96.5(3), 96.6(1), 96.6(2), 96.16, 96.19(6)*"a,"* and 96.19(38).

871—24.26(96) Voluntary quit with good cause attributable to the employer and separations not considered to be voluntary quits. The following are reasons for a claimant leaving employment with good cause attributable to the employer:

24.26(1) A change in the contract of hire. An employer's willful breach of contract of hire shall not be a disqualifiable issue. This would include any change that would jeopardize the worker's safety, health or morals. The change of contract of hire must be substantial in nature and could involve changes in working hours, shifts, remuneration, location of employment, drastic modification in type of work, etc. Minor changes in a worker's routine on the job would not constitute a change of contract of hire.

24.26(2) The claimant left due to unsafe working conditions.

24.26(3) The claimant left due to unlawful working conditions.

24.26(4) The claimant left due to intolerable or detrimental working conditions.

24.26(5) The claimant was laid off by the employer for being pregnant; however, availability must still be determined.

24.26(6) Separation because of illness, injury, or pregnancy.

a. Nonemployment related separation. The claimant left because of illness, injury or pregnancy upon the advice of a licensed and practicing physician. Upon recovery, when recovery was certified by a licensed and practicing physician, the claimant returned and offered to perform services to the employer, but no suitable, comparable work was available. Recovery is defined as the ability of the claimant to perform all of the duties of the previous employment.

b. Employment related separation. The claimant was compelled to leave employment because of an illness, injury, or allergy condition that was attributable to the employment. Factors and circumstances directly connected with the employment which caused or aggravated the illness, injury, allergy, or disease to the employee which made it impossible for the employee to continue in employment because of serious danger to the employee's health may be held to be an involuntary termination of employment and constitute good cause attributable to the employer. The claimant will be eligible for benefits if compelled to leave employment as a result of an injury suffered on the job.

In order to be eligible under this paragraph *"b"* an individual must present competent evidence showing adequate health reasons to justify termination; before quitting have informed the employer of the work-related health problem and inform the employer that the individual intends to quit unless the problem is corrected or the individual is reasonably accommodated. Reasonable accommodation includes other comparable work which is not injurious to the claimant's health and for which the claimant must remain available.

24.26(7) Reserved.

24.26(8) The claimant left for the necessary and sole purpose of taking care of a member of the claimant's immediate family who was ill or injured, and after that member of the claimant's family was sufficiently recovered, the claimant immediately returned and offered to perform services to the employer, but no work was available. Immediate family is defined as a collective body of persons who live under one roof and under one head or management, or a son or daughter, stepson, stepdaughter, father, mother, father-in-law, mother-in-law. Members of the immediate family must be related by blood or by marriage.

24.26(9) The claimant left employment upon the advice of a licensed and practicing physician for the sole purpose of taking a family member to a place having a different climate and subsequently returned to the claimant's regular employer and offered to perform services, but the claimant's regular or comparable work was not available. However, during the time the claimant was at a different climate the claimant shall be deemed to be unavailable for work notwithstanding that during the absence the claimant secured temporary employment. (Family is defined as: wife, husband, children, parents, grandparents, grandchildren, foster children, brothers, brothers-in-law, sisters, sisters-in-law, aunts, uncles or corresponding relatives of the classified employee's spouse or other relatives of the classified employee or spouse residing in the classified employee's immediate household.)

24.26(10) A claimant who underwent a mandatory retirement as of a certain age because of company policy or in accordance with an agreement between the employer and union.

24.26(11) The granting of a written release from employment by the employer at the employee's request is a mutual termination of employment and not a voluntary quit. However, this would constitute a period of voluntary unemployment by the employee and the employee would not meet the availability requirement of Iowa Code section 96.4(3).

24.26(12) When an employee gives notice of intent to resign at a future date, it is a quit issue on that future date. Should the employer terminate the employee immediately, such employee shall be eligible for benefits for the period between the actual separation and the future quit date given by the claimant.

24.26(13) A claimant who, when told of a scheduled future layoff, leaves employment before the layoff date shall be deemed to be not available for work until the future separation date designated by the employer. After the employer-designated date, the separation shall be considered a layoff.

24.26(14) Rescinded IAB 7/28/99, effective 9/1/99.

24.26(15) Employee of temporary employment firm.

a. The individual is a temporary employee of a temporary employment firm who notifies the temporary employment firm within three days of completion of an employment assignment and seeks reassignment under the contract of hire. The employee must be advised by the employer of the notification requirement in writing and receive a copy.

b. The individual shall be eligible for benefits under this subrule if the individual had good cause for not contacting the employer within three days and did notify the employer at the first reasonable opportunity.

c. Good cause is a substantial and justifiable reason, excuse or cause such that a reasonable and prudent person, who desired to remain in the ranks of the employed, would find to be adequate justification for not notifying the employer. Good cause would include the employer's going out of business; blinding snow storm; telephone lines down; employer closed for vacation; hospitalization of the claimant; and other substantial reasons.

d. Notification may be accomplished by going to the employer's place of business, telephoning the employer, faxing the employer, or any other currently accepted means of communications. Working days means the normal days in which the employer is open for business.

24.26(16) The claimant left employment for a period not to exceed ten working days or such additional time as was allowed by the employer, for compelling personal reasons and prior to leaving claimant had informed the employer of such compelling personal reasons, and immediately after such compelling personal reasons ceased to exist or at the end of ten working days, whichever occurred first, the claimant returned to the employer and offered to perform services, but no work was available. However, during the time the claimant was away from work because of the continuance of this compelling personal reason, such claimant shall be deemed to be not available for work.

24.26(17) Reserved.

24.26(18) Reserved.

24.26(19) The claimant was employed on a temporary basis for assignment to spot jobs or casual labor work and fulfilled the contract of hire when each of the jobs was completed. An election not to report for a new assignment to work shall not be construed as a voluntary leaving of employment. The issue of a refusal of an offer of suitable work shall be adjudicated when an offer of work is made by the former employer. The provisions of Iowa Code section 96.5(3) and rule 24.24(96) are controlling in the

determination of suitability of work. However, this subrule shall not apply to substitute school employees who are subject to the provisions of Iowa Code section 96.4(5) which denies benefits that are based on service in an educational institution when the individual declines or refuses to accept a new contract or reasonable assurance of continued employment status. Under this circumstance, the substitute school employee shall be considered to have voluntarily quit employment.

24.26(20) The claimant left work voluntarily rather than accept a transfer to another locality that would have caused a considerable personal hardship.

24.26(21) The claimant was compelled to resign when given the choice of resigning or being discharged. This shall not be considered a voluntary leaving.

24.26(22) The claimant was hired for a specific period of time and completed the contract of hire by working until this specific period of time had lapsed. However, this subrule shall not apply to substitute school employees who are subject to the provisions of Iowa Code section 96.4(5) which denies benefits that are based on service in an educational institution when the individual declines or refuses to accept a new contract or reasonable assurance of continued employment status. Under this circumstance, the substitute school employees shall be considered to have voluntarily quit employment.

24.26(23) The claimant left work because the type of work was misrepresented to such claimant at the time of acceptance of the work assignment.

24.26(24) Reserved.

24.26(25) Temporary active military duty. A member of the national guard or organized military reserves of the armed forces of the United States ordered to temporary active duty for the purpose of military training or ordered on active state service, shall be entitled to a leave of absence during the period of such duty. The employer shall restore such person to the position held prior to such leave of absence, or employ such person in a similar position; provided, that such person shall give evidence to the employer of satisfactory completion of such training or duty, and further provided that such person is still qualified to perform the duties of such position.

24.26(26) Reserved.

24.26(27) Refusal to exercise bumping privilege. An individual who has left employment in lieu of exercising the right to bump or oust a fellow employee with less seniority shall be eligible for benefits.

24.26(28) The claimant left the transferring employer and accepted work with the acquiring employer at the time the employer acquired a clearly segregable and identifiable part of the transferring employer's business or enterprise. Under this condition, the balancing account shall immediately become chargeable for the benefits paid which are based on the wages paid by the transferring employer, provided the acquiring employer does not receive a partial successorship, and no disqualification shall be imposed if the claimant is otherwise eligible.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(3), 96.4(5), 96.5(1), 96.5(3), 96.6(1), 96.16, and 96.19(38).

871—24.27(96) Voluntary quit of part-time employment and requalification. An individual who voluntarily quits without good cause part-time employment and has not requalified for benefits following the voluntary quit of part-time employment, yet is otherwise monetarily eligible for benefits based on wages paid by the regular or other base period employers, shall not be disqualified for voluntarily quitting the part-time employment. The individual and the part-time employer which was voluntarily quit shall be notified on the Form 65-5323 or 60-0186, Unemployment Insurance Decision, that benefit payments shall not be made which are based on the wages paid by the part-time employer and benefit charges shall not be assessed against the part-time employer's account; however, once the individual has met the requalification requirements following the voluntary quit without good cause of the part-time employer, the wages paid in the part-time employment shall be available for benefit payment purposes. For benefit charging purposes and as determined by the applicable requalification requirements, the wages paid by the part-time employer shall be transferred to the balancing account.

This rule is intended to implement Iowa Code section 96.5(1)*"g."*

871—24.28(96) Voluntary quit requalifications and previously adjudicated voluntary quit issues.

24.28(1) The claimant shall be eligible for benefits even though having voluntarily left employment, if subsequent to leaving such employment, the claimant worked in (except in back pay awards) and was paid wages for insured work equal to ten times the claimant's weekly benefit amount.

24.28(2) The claimant shall be eligible for benefits even though having been previously disqualified from benefits due to voluntary quit, if subsequent to the disqualification, the claimant worked in (except in back pay awards) and was paid wages for insured work equal to ten times the claimant's weekly benefit amount.

24.28(3) Reserved.

24.28(4) Reserved.

24.28(5) The claimant shall be eligible for benefits even though the claimant voluntarily quit if the claimant left for the sole purpose of accepting an offer of other or better employment, which the claimant did accept, and from which the claimant is separated, before or after having started the new employment. The employment does not have to be covered employment and does not include self-employment.

24.28(6) The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by a representative of the department and such decision has become final.

24.28(7) The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by the administrative law judge and such decision has become final.

24.28(8) The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by the employment appeal board and such decision has become final.

This rule is intended to implement Iowa Code section 96.5(1)*"a."*

871—24.29(96) Business closing.

24.29(1) Whenever an employer at a factory, establishment, or other premises goes out of business at which the individual was last employed and is laid off, the individual's account is credited with one-half, instead of one-third, of the wages for insured work paid to the individual during the individual's base period, which may increase the maximum benefit amount up to 39 times the weekly benefit amount or one-half of the total base period wages, whichever is less. This rule also applies retroactively for monetary redetermination purposes during the current benefit year of the individual who is temporarily laid off with the expectation of returning to work once the temporary or seasonal factors have been eliminated and is prevented from returning to work because of the going out of business of the employer within the same benefit year of the individual. This rule also applies to an individual who works in temporary employment between the layoff from the business closing employer and the Claim for Benefits. For the purposes of this rule, temporary employment means employment of a duration not to exceed four weeks.

24.29(2) Going out of business means any factory, establishment, or other premises of an employer which closes its door and ceases to function as a business; however, an employer is not considered to have gone out of business at the factory, establishment, or other premises in any case in which the employer sells or otherwise transfers the business to another employer, and the successor employer continues to operate the business.

24.29(3) Verification of going out of business. When the unemployment insurance representative is informed by the individual or has knowledge of an employer going out of business at a factory, establishment, or other premises, the unemployment insurance representative completes a Form 60-0240, Verification of Business Closing, and refers Form 60-0240 to the field audit section for assignment to a field auditor who verifies the business closing. A Form 62-2056, Review of Business Status for Closing Credits, is completed for each succeeding claimant who requests to be included in a redetermination for business closing credits. This form is added to the Form 60-0240 already in the department file for the appropriate pending investigation. Upon return of the Form 60-0240 from the field audit section, an unemployment insurance representative will issue the appropriate decisions to all claimants who

requested that their unemployment insurance claim be redetermined as a business closing based on the results of the investigation.

871—24.30 Reserved.

871—24.31(96) Subsequent benefit year condition.

24.31(1) The claimant must have been paid benefits on a previous claim.

24.31(2) If the claimant has the qualifying wages for the establishment of a second benefit year as specified in Iowa Code section 96.4(4) which were earned prior to the filing of the previous claim, the claimant must, during or subsequent to that year, have worked in (except in back pay awards) and have been paid wages for insured work totaling at least $250, to fulfill the condition to be eligible for benefits on a new claim. Vacation pay, severance pay and bonuses are not considered as wages for second benefit year requalification purposes.

24.31(3) Insured work means insured work in any state.

24.31(4) Employment for a railroad under the Railroad Unemployment Insurance Act is insured work.

24.31(5) The amount equal to $250 in insured work need not be in addition to the qualifying wages for the establishment of a second benefit year.

24.31(6) Disqualification for lack of the $250 in insured work shall be removed upon the verification that the claimant worked in and has been paid wages for insured work totaling $250 during or subsequent to the previous benefit year.

This rule is intended to implement Iowa Code section 96.4(4).

871—24.32(96) Discharge for misconduct.

24.32(1) *Definition.*

a. "Misconduct" is defined as a deliberate act or omission by a worker which constitutes a material breach of the duties and obligations arising out of such worker's contract of employment. Misconduct as the term is used in the disqualification provision as being limited to conduct evincing such willful or wanton disregard of an employer's interest as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of employees, or in carelessness or negligence of such degree of recurrence as to manifest equal culpability, wrongful intent or evil design, or to show an intentional and substantial disregard of the employer's interests or of the employee's duties and obligations to the employer. On the other hand mere inefficiency, unsatisfactory conduct, failure in good performance as the result of inability or incapacity, inadvertencies or ordinary negligence in isolated instances, or good faith errors in judgment or discretion are not to be deemed misconduct within the meaning of the statute.

b. Any individual who has been discharged or suspended for misconduct connected with work is disqualified for benefits until the individual has worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

24.32(2) Reserved.

24.32(3) *Gross misconduct.*

a. For the purposes of these rules gross misconduct shall be defined as misconduct involving an indictable offense in connection with the claimant's employment, provided that such claimant is duly convicted thereof or has signed a statement admitting that such claimant has committed such act.

b. An indictable offense means a common law or statutory offense presented on indictment or on county attorney's information, and includes all felonies and all indictable misdemeanors punishable by a fine of more than $500 or by imprisonment in the county jail for more than 30 days.

24.32(4) *Report required.* The claimant's statement and employer's statement must give detailed facts as to the specific reason for the claimant's discharge. Allegations of misconduct or dishonesty without additional evidence shall not be sufficient to result in disqualification. If the employer is unwilling to furnish available evidence to corroborate the allegation, misconduct cannot be established.

In cases where a suspension or disciplinary layoff exists, the claimant is considered as discharged, and the issue of misconduct shall be resolved.

24.32(5) *Trial period.* A dismissal, because of being physically unable to do the work, being not capable of doing the work assigned, not meeting the employer's standards, or having been hired on a trial period of employment and not being able to do the work shall not be issues of misconduct.

24.32(6) *False work application.* When a willfully and deliberately false statement is made on an Application for Work form, and this willful and deliberate falsification does or could result in endangering the health, safety or morals of the applicant or others, or result in exposing the employer to legal liabilities or penalties, or result in placing the employer in jeopardy, such falsification shall be an act of misconduct in connection with the employer.

24.32(7) *Excessive unexcused absenteeism.* Excessive unexcused absenteeism is an intentional disregard of the duty owed by the claimant to the employer and shall be considered misconduct except for illness or other reasonable grounds for which the employee was absent and that were properly reported to the employer.

24.32(8) *Past acts of misconduct.* While past acts and warnings can be used to determine the magnitude of a current act of misconduct, a discharge for misconduct cannot be based on such past act or acts. The termination of employment must be based on a current act.

24.32(9) *Suspension or disciplinary layoff.* Whenever a claim is filed and the reason for the claimant's unemployment is the result of a disciplinary layoff or suspension imposed by the employer, the claimant is considered as discharged, and the issue of misconduct must be resolved. Alleged misconduct or dishonesty without corroboration is not sufficient to result in disqualification.

This rule is intended to implement Iowa Code section 96.5 and Supreme Court of Iowa decision, *Sheryl A. Cosper vs. Iowa Department of Job Service and Blue Cross of Iowa*.

871—24.33(96) Labor disputes.

24.33(1) *Definition.* As used in sections 96.5(3)*"b"*(1) and 96.5(4), the term labor dispute shall mean any controversy concerning terms, tenure, or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment regardless of whether the disputants stand in the proximate relation of employer and employee. An individual shall be disqualified for benefits if unemployment is due to a labor dispute.

24.33(2) *Initial requirements—workforce development center.*

a. As soon as the workforce development center has knowledge of a labor dispute or work stoppage in its administrative area, a report on Form 68-0535, Labor Dispute Report, shall be sent to the administrative office of the department of workforce development, attention: legal counsel, unemployment insurance services division, advising of the labor dispute or work stoppage.

b. If the labor dispute or work stoppage is terminated before the report is transmitted to the legal counsel, unemployment insurance services division, the information concerning the termination of the dispute and the date of the worker's return to work must also be entered on Form 68-0535.

c. When the labor dispute or work stoppage is terminated subsequent to the filing of the initial Form 68-0535, the legal counsel, unemployment insurance services division, shall be notified of the termination and return to work dates.

d. In those instances where an association represents a group of employers, include the names and addresses of the employers who are involved in the labor dispute in your report. Include also the name and address of the association and the name of the association official who can furnish information about the work stoppage.

e. In taking initial claims in which there is a labor dispute, the workforce development center will complete an initial application for unemployment, Form 60-0330, Application for Job Placement Assistance and/or Job Insurance, in the normal manner and will also include the union name and local union number.

f. If a claim notice is inadvertently returned by the employer to the workforce development center stating there is a labor dispute, the protest with the postmarked envelope attached shall be transmitted to the unemployment insurance service center.

g. If there is a work stoppage at the premises of an employer and it is a known fact that there has not been a union and that at present there is no union representation nor any attempt by a union to organize the workers of the plant, a statement must be taken from each individual claiming benefits.

h. Statements from each individual claiming benefits are not required on the labor dispute issue whenever there is union representation even though some of the individuals may not be union members.

i. Statements from each individual claiming benefits will be taken whenever the work stoppage is considered as a nonunion stoppage, meaning no union representation at the premises of the employer. In such cases, each individual's statement would become a part of the evidence submitted to the administrative office of the department of workforce development.

j. When there is a termination of the work stoppage, or if the issues have not been resolved and all workers returned to work, a report must be made to the legal counsel, unemployment insurance services division. The report will include the:

(1) Date on which an agreement was reached on the issues which caused the work stoppage.

(2) Date on which the workers returned to work, or a schedule as to how the workers will return to work.

k. The requirements in subrules 24.33(1) and 24.33(2) will cover the establishment and termination reports of the work stoppage and give the information necessary for the claims section to investigate the work stoppage when claims are filed on which a protest is made that the claimant is involved in a work stoppage.

l. During the period of a labor dispute, the claims involved in the labor dispute are processed as though no separation from the employer had occurred. Therefore, if an individual is still unemployed after the termination of the labor dispute, such individual has either been laid off, voluntarily left, or has been discharged from employment, and an additional claim must be taken if the individual continues in claim status.

m. When the employer or the union requests advice and information pertaining to what action should be taken in regard to the labor dispute, the workforce development center, at that time, should obtain all the information possible from the caller for inclusion in the labor dispute report to the unemployment insurance services division.

n. The employer will receive separate notices of claim filing for each claimant and shall make any protest in the appropriate section on the reverse side of Form 65-5317, Notice of Claim. The employer will receive a copy of the decision which may be appealed.

o. Form 65-5317, Notice of Claim Filing, will be used by the employer to report total unemployment due to strike, lockout or other labor dispute.

p. Employer shall use Form 60-0154, Notice of Separation or Refusal of Work, or the electronic version of that form, to report separations from work by employees for reasons of voluntary leaving, misconduct and job refusal. Form 60-0154 shall not be used by employers to report labor disputes because the document is not designed for that type of an employment separation or work refusal.

24.33(3) *Initial determination.*

a. In any case in which the payment or denial of benefits will be determined by the provisions of Iowa Code section 96.5(4), the representative of the unemployment insurance services division shall promptly review the evidence submitted, and such additional evidence as may be required, and shall make a decision upon the issues involved under that subsection.

b. The representative of the unemployment insurance services division shall promptly notify all interested parties to the claim of the decision. Said parties shall have ten days, from the date of mailing the decision to the last known address of record, to appeal the decision.

871—24.34(96) Labor dispute—policy.

24.34(1) Reserved.

24.34(2) Union membership in and of itself is not the determinative factor in whether an individual is participating in, financing or directly interested in the labor dispute.

24.34(3) The relationship between employer and employee continues during the period of the labor dispute unless severed by the employer or employee.

a. If the relationship is severed by the employer, Iowa Code section 96.5(2) concerning discharge for misconduct shall govern.

b. If the relationship is severed by the employee, Iowa Code section 96.5(1) concerning voluntary leaving shall govern.

24.34(4) An individual who is unemployed because of a labor dispute and accepts employment elsewhere during the period of the labor dispute, must return to the previous employer when said labor dispute is settled or be subject to a determination on the issue of voluntary leaving.

24.34(5) Any individual unemployed because of failure or refusal to cross a picket line during a labor dispute shall be deemed to be involved in such labor dispute.

24.34(6) If an initial determination by the representative of the unemployment insurance services division of a labor dispute issue is appealed, the case shall be assigned to an administrative law judge, who shall receive the testimony of any party to the hearing and shall issue a decision on the labor dispute. Such decision may be appealed in conformity with these rules to the employment appeal board of the Iowa department of inspections and appeals.

24.34(7) An individual not involved in or participating in a labor dispute who failed to report to work because of a picket line shall be deemed to have voluntarily left employment. However, if the individual was subjected to hostility or violence in an attempt to cross a picket line, then the individual shall be deemed to have involuntarily left employment.

a. The division shall presume that any strike or lockout is being conducted in a lawful manner unless evidence to the contrary has been introduced. The division shall presume that any picketing is being conducted in a peaceful manner and that ingress or egress to the employer's facility is not being unlawfully impeded.

b. The division shall presume that where an injunction has been sought against actual or threatened violence, unlawful impedance of ingress or egress, or other unlawful conduct and such injunction shall have been denied on the basis that actual or threatened unlawful conduct has not been established that the picket line is peaceful unless evidence is introduced which establishes the violent nature of picket line activity.

c. If an injunction is obtained, the division shall presume the picket line is peaceful as of the date the injunction is issued unless evidence is introduced which proves the contrary proposition.

24.34(8) A lockout is not a labor dispute if the claimant is willing to continue working under the preexisting terms and conditions of the expired collective bargaining agreement for a reasonable period of time while a new collective bargaining agreement is negotiated. A lockout is a cessation of the furnishing of work to employees or a withholding of work from them in an effort to get more desirable terms for the employer.

a. The test for determining whether a stoppage of work is a lockout or labor dispute is to determine the final cause and the party ultimately responsible for the work stoppage. If the employees have offered to continue working for a reasonable period of time under the preexisting terms and conditions of employment so as to avert a work stoppage pending the final settlement of the contract negotiations and the employer refuses to maintain the status quo by extending the expired contract, the resulting work stoppage constitutes a lockout and the claimants shall not be disqualified because of a labor dispute.

b. A cessation of employment by the employer is not a lockout if:

(1) The stoppage of work is in the same facility or another facility of the employer and the claimant is directly involved in the labor dispute and the collective bargaining negotiations will directly affect the claimant's condition of employment, or

(2) The claimant or the recognized collective bargaining agent declines an offer from the employer to extend the expired collective bargaining agreement while negotiations continue for a reasonable period of time taking into consideration the nature of the employer's business, or

(3) The employer can demonstrate that its refusal to allow employees to continue working under the terms and conditions of the expired collective bargaining agreement is due to a compelling reason of such degree that the extension of the contract would be unreasonable under the circumstances.

24.34(9) To constitute a labor dispute there must be a stoppage of work at the plant or establishment. If there is no stoppage of work, the individual who leaves employment shall be deemed to have voluntarily quit.

24.34(10) When individuals, not as a group, union, or under union direction or suggestion but individually, left their work voluntarily in protest against the discharge of a fellow employee by their employer, in an unauthorized strike, it is held to be a voluntary quit.

24.34(11) Employment offered by an employer involved in a labor dispute or an employer who becomes involved in a labor dispute prior to acceptance by the claimant is considered:

a. Not suitable if the offer is made to a person who would be a new employee or a former employee who was laid off before the labor dispute and the vacancy was created by the strike, lockout, or other labor dispute.

b. Suitable if the offer was made to a former employee, who was previously laid off, provided the position offered is not vacant because of the strike, lockout, or other labor dispute and the provisions of section 96.5(4) shall apply.

c. Suitable if the offer is made to a new employee, who was not previously laid off by the same employer, and the vacancy was not created by a labor dispute.

24.34(12) Other employment accepted during periods of labor disputes does not free the claimant from the labor dispute section of the Iowa employment security law unless the claimant severs relationship with employer and obtains bona fide employment elsewhere.

This rule is intended to implement Iowa Code sections 96.5(3) and 96.5(4).

871—24.35(96) Date of submission and extension of time for payments and notices.

24.35(1) Except as otherwise provided by statute or by division rule, any payment, appeal, application, request, notice, objection, petition, report or other information or document submitted to the division shall be considered received by and filed with the division:

a. If transmitted via the United States postal service on the date it is mailed as shown by the postmark, or in the absence of a postmark the postage meter mark of the envelope in which it is received; or if not postmarked or postage meter marked or if the mark is illegible, on the date entered on the document as the date of completion.

b. If transmitted by any means other than the United States postal service on the date it is received by the division.

24.35(2) The submission of any payment, appeal, application, request, notice, objection, petition, report or other information or document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the division that the delay in submission was due to division error or misinformation or to delay or other action of the United States postal service.

a. For submission that is not within the statutory or regulatory period to be considered timely, the interested party must submit a written explanation setting forth the circumstances of the delay.

b. The division shall designate personnel who are to decide whether an extension of time shall be granted.

c. No submission shall be considered timely if the delay in filing was unreasonable, as determined by the division after considering the circumstances in the case.

d. If submission is not considered timely, although the interested party contends that the delay was due to division error or misinformation or delay or other action of the United States postal service, the division shall issue an appealable decision to the interested party.

24.35(3) Any notice, report form, determination, decision, or other document mailed by the division shall be considered as having been given to the addressee to whom it is directed on the date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated by the facts.

871—24.36(96) Interstate benefits.

24.36(1) An interstate claimant is an individual who claims benefits under the unemployment insurance law of one or more liable states. Interstate benefits are payable under the plan approved by the national association of state workforce agencies to unemployed individuals absent from the state(s) in which wage credits were earned.

24.36(2) The division shall determine unemployment benefit claims for interstate claimants in accordance with applicable state law and rules and shall be in substantial compliance with those rules promulgated by the United States Department of Labor as published in the Code of Federal Regulations, Chapter 20, Parts 609, 615, 616, 617, and 650.

871—24.37(96) Payment of benefits to interstate claimants.

24.37(1) Section 96.20 of the employment security law of Iowa authorizes the department to enter into reciprocal arrangements with appropriate and duly authorized agencies of other states or of the federal government, or both. In conformity with this section, the department of workforce development prescribes:

a. Applicability. This regulation shall govern the department in its administrative cooperation with other states adopting a similar regulation for the payment of unemployment insurance benefits to interstate claimants.

b. Definitions. As used in this rule unless the context clearly requires otherwise:

(1) *"Interstate benefit payment plan."* This is the plan approved by the national association of state workforce agencies under which benefits shall be payable to unemployed individuals absent from the state (or states) in which benefit credits have been accumulated.

(2) *"Interstate claimant."* This is an individual who claims benefits under the unemployment insurance law of one or more liable states. The term interstate claimant shall not include any individual who customarily commutes from a residence in an agent state to work in a liable state unless the department finds that this exclusion would create undue hardship on such a claimant in a specified area.

(3) *"State."* This includes the District of Columbia, Puerto Rico, the Virgin Islands and Canada.

(4) *"Agent state."* This means any state in which an individual files a claim for benefits from another state.

(5) *"Liable state."* A liable state is any state against which an individual files, from another state, a claim for benefits.

(6) *"Benefits."* This is the compensation payable to an individual, with respect to unemployment, under the employment security law of any state.

(7) *"Week of unemployment."* This is any week of unemployment as defined in the law of the liable state from which benefits with respect to such week are claimed.

c. Registration for work.

(1) Each interstate claimant shall be registered for work, through any public employment office in the agent state when and as required by the law, rules, regulations, and procedures of the agent state. Such registration shall be accepted as meeting the registration requirements of the liable state.

(2) Each agent state shall duly report to the liable state in question whether each interstate claimant meets the registration requirements of the agent state.

d. Benefit rights of interstate claimants.

(1) If a claimant files a claim against any state, and it is determined by such state that the claimant has available benefit credits in such state, then claims shall be filed only against such state as long as benefit credits are available in that state. Thereafter, the claimant may file claims against any other state in which there are available benefit credits.

(2) For the purposes of this regulation, benefit credits shall be deemed to be unavailable whenever benefits have been exhausted, terminated, or postponed for an indefinite period or for the entire period in which benefits would otherwise be payable, or whenever benefits are affected by the application of a seasonal restriction. The department will respect the prior adjudication of a liable state if the department is made aware of the decision and will apply the Iowa requalification criteria, unless the claimant has requalified pursuant to the liable state's requalification criteria.

(3) The benefit rights of interstate claimants established by this regulation shall apply only with respect to new claims filed on or after July 5, 1953.

e. Claim for benefits.

(1) Claims for benefits shall be filed by interstate claimants on uniform interstate claim forms or by using the procedures provided by the liable state and in accordance with uniform procedures developed pursuant to the interstate benefit payment plan. Claims shall be filed in accordance with the type of week in use in the agent state. Any adjustments required to fit the type of week used by the liable state shall be made by the liable state on the basis of consecutive claims filed.

(2) Rescinded IAB 8/6/03, effective 9/10/03.

f. Determination of claims.

(1) In connection with each claim filed by an interstate claimant, the agent state shall ascertain and report to the liable state in question such facts relating to the claimant's availability for work and eligibility for benefits as are readily determinable in and by the agent state.

(2) The agent state's responsibility and authority in connection with the determination of interstate claims shall be limited to investigation and reporting of relevant facts. The agent state shall not refuse to take an interstate claim unless the liable state has a procedure for taking out-of-state claims.

g. Appellate procedure.

(1) The agent state shall afford all reasonable cooperation in the taking of evidence and the holding of hearings in connection with appealed interstate benefit claims.

(2) With respect to the time limits imposed by the law of a liable state upon the filing of an appeal in connection with a disputed benefit claim, an appeal made by an interstate claimant shall be deemed to have been made and communicated to the liable state on the date when it is received by any qualified representative of the agent state.

24.37(2) *Extended benefits interstate claims.* When extended benefits are in effect and a claimant is filing for extended benefits, an eligible individual shall be limited to a maximum of two weeks of the extended benefit entitlement if the individual moves from this state, before or during an extended benefit period triggered by this state's "on" indicator, to another state in which an extended benefit period is not in effect.

This rule is intended to implement Iowa Code sections 96.6(1) and 96.29(3).

871—24.38(96) Combined wage claim.

24.38(1) *Purpose of plan.* The combined wage program is to enable an unemployed worker with covered employment or wages in more than one state to combine all such employment and wages in one state in order to qualify for benefits or to receive increased benefits.

a. Each state will cooperate with every other state by implementing these uniform combined wage procedures, rules and regulations. This includes the District of Columbia, U.S. Virgin Islands and the Commonwealth of Puerto Rico.

b. The benefit year, base period, qualifying wages, benefit rate, and duration of benefits under the unemployment compensation law of the paying state shall be the benefit year, base period, qualifying wages, benefit rate, and duration of benefits applicable to a combined wage claimant.

c. The rights of the individual under the combined wage claim plan shall be determined by the paying state after the combining of all wages available from the transferring states; however, in the case in which another state transfers wages to Iowa and Iowa is the paying state, Iowa cannot again adjudicate a separation that has been previously adjudicated by the transferring state. The department shall respect the prior adjudication of the transferring state if the department is aware of the decision and will apply the Iowa requalification criteria, unless the individual has requalified pursuant to the liable state's requalification criteria.

d. All other provisions of the unemployment compensation laws and rules of the state agency of the paying state shall be applied to the combined wage claim.

e. The state in which the claim is filed will be the paying state except in those cases in which the individual does not qualify after the transfer has been completed or if the claimant meets the definition of a commuter.

24.38(2) *Exception to combining wage credits.* Under the following circumstances, wages and employment are not transferable to the paying state:

a. Any employment and wages which have been transferred to any other paying state and not returned unused.

b. Wages that have been used by the transferring state as the basis of a monetary determination which established a benefit year.

c. Any employment and wages that have been canceled or are unavailable as a result of a transferring state determination made prior to the request for transfer.

24.38(3) The claimant will be told that if there was a previous election to file a combined wage claim, the claimant may withdraw the combined wage claim any time, up to the date the paying state's monetary determination becomes final. However, if the claimant withdraws a combined wage claim and benefits have been paid, the claimant will be required to repay any such benefits. This repayment may be done by cash or by an authorization to the state(s) from which such claimant next claims benefits to reimburse the combined wage paying state for any benefits which said claimant will be paid.

871—24.39(96) Department-approved training or retraining program. The intent of department-approved training is to exempt the individual from the work search requirement for continued eligibility for benefits so individuals may pursue training that will upgrade necessary skills in order to return to the labor forces. In order to be eligible for department-approved training programs and to maintain continuing participation therein, the individual shall meet the following requirements:

24.39(1) Any claimant for benefits who desires to receive benefits while attending school for training or retraining purposes shall make a written application to the department setting out the following:

a. The educational establishment at which the claimant would receive training.

b. The estimated time required for such training.

c. The occupation which the training is allowing the claimant to maintain or pursue.

24.39(2) A claimant may receive unemployment insurance while attending a training course approved by the department. While attending the approved training course, the claimant need not be available for work or actively seeking work. After completion of department-approved training the claimant must, in order to continue to be eligible for unemployment insurance, place no restriction on employability. The claimant must be able to work, available for work and be actively searching for work. In addition, the claimant may be subject to disqualification for any refusal of work without good cause after the claimant has completed the training.

24.39(3) The claimant must show satisfactory attendance and progress in the training course and must demonstrate that such claimant has the necessary finances to complete the training to substantiate the expenditure of unemployment insurance funds.

This rule is intended to implement Iowa Code section 96.4(6).

871—24.40(96) Training extension benefits.

24.40(1) The purpose of training extension benefits is to provide the individual with continued eligibility for benefits so that the individual may pursue a training program for entry into a high-demand or high-technology occupation. Training extension benefits are available to an individual who was laid off or voluntarily quit with good cause attributable to the individual's employer from full-time employment in a declining occupation or is involuntarily separated from full-time employment as a result of a permanent reduction of operations.

24.40(2) The weekly benefit amount shall be pursuant to the same terms and conditions as regular unemployment benefits and the benefits shall be for a maximum of 26 times the weekly benefit amount of the claim which resulted in eligibility. Both contributory and reimbursable employers shall be relieved of charges for training extension benefits.

24.40(3) The course or courses must be for a high-demand or high-technology occupation. The department will make available to serve as a guide a list of high-demand, high-technology, and declining occupations. The lists shall be available on the department's Web site and workforce centers.

a. High-technology occupations include life sciences, advanced manufacturing, biotechnology, alternative fuels, insurance, environmental technology, and technologically advanced green jobs. A high-technology occupation is one which requires a high degree of training in the sciences, engineering, or other advanced learning area and has work opportunities available in the labor market area or the state of Iowa.

b. A high-demand occupation means an occupation in a labor market area or the state of Iowa as a whole in which the department determines that work opportunities are available.

c. A declining occupation has a lack of sufficient current demand in the individual's labor market area or the state of Iowa for the occupational skills possessed by the individual, and the lack of employment opportunities is expected to continue for an extended period of time.

d. A declining occupation includes an occupation for which there is a seasonal variation in demand in the labor market or the state of Iowa, and the individual has no other skill for which there is a current demand.

e. A declining or high-demand occupation will be determined by using Iowa labor market information for each region in the state.

24.40(4) The individual must be enrolled in the training no later than the end of the benefit year which included the separation which made the individual eligible for training benefits or the week in which any federal benefit program based upon that benefit year is exhausted. Enrolled before the end of the benefit year means the individual has taken all steps available for entry into the training and has secured a reserved position in the training class. The individual has paid tuition or will pay tuition when the training starts. The training class may begin after the end of the benefit year. The application for training benefits must be received 30 days after the end of the benefit year or 30 days after federal benefits are exhausted. The individual must be enrolled and making satisfactory progress to complete the training program in order to continue to be eligible for training extension benefits.

24.40(5) Training benefits shall cease to be available if the training is completed; the individual quits the training course; the individual exhausts the training extension maximum benefit amount; or the individual fails to make satisfactory progress; and benefits shall cease no later than one calendar year following the end of the benefit year in which the individual became eligible for the benefits. Individuals must file and receive benefits under any federal or state unemployment insurance benefit program until the claim has expired or has been exhausted, in order to maintain eligibility for training extension benefits.

This rule is intended to implement 2009 Iowa Code Supplement section 96.3(5).

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—24.41(96) Unemployed parents program (FIP/UP). Under Public Law 94-566, an unemployed parent who is eligible for both unemployment insurance and family investment program/unemployed parent (FIP/UP) shall be required to collect any unemployment insurance to which the individual is entitled before receiving any payments under the FIP/UP program.

This rule is intended to implement Iowa Code chapter 91 and Public Law 94-566.

871—24.42(96) Retention of DHS referral form. When an unemployed parent presents the DHS referral Form PA-2138-5 to the workforce development center representative, the representative will take the form, sign it and complete an application for job placement assistance and/or employment insurance benefits.

24.42(1) The weekly benefit amount and maximum benefit amount of the claimant will be entered in job service comments on Form PA-2138-5. If the person is not monetarily eligible, that notation will be entered and the form mailed to human services.

24.42(2) A FIP/UP claimant may have the claim protested which can affect eligibility. Human services may request additional information on a subsequent Form PA-2138-5 concerning nonmonetary allowances or disqualifications on the claim, which will be furnished in the comments section of the form.

This rule is intended to implement Iowa Code chapter 91 and Public Law 94-566.

871—24.43 and **24.44** Reserved.

871—24.45(96) Trade Act of 1974. Unemployment benefits payable to claimants under the Trade Act of 1974 (P.L. 93-618), shall be determined in accordance with the rules of the United States department of labor as published in the Code of Federal Regulations, chapter 29, parts 70 and 91. The Trade Act of 1974 is designed to pay unemployment benefits to workers who become unemployed due to foreign production of goods replacing domestic production.

871—24.46(96) Extended benefits.

24.46(1) *Purpose.* Extended benefits are benefits paid to an eligible individual during periods of high unemployment in a state under the Federal-State Extended Unemployment Compensation Act of 1970 and the Extended Benefit Program Regulations under 20 Code of Federal Regulations Part 615. The purpose of extended benefits is to extend the period of time for which an individual may receive benefits to allow the individual additional time to locate employment in recognition of the likelihood that employment is more difficult to find during periods of high unemployment in a state. The cost of extended benefits is shared between the federal and state governments.

24.46(2) *Determination of when extended benefits are paid.*

a. When paid. The state "on" indicator determines when extended benefits are paid in this state. A state "on" indicator is in effect during a week for which the rate of insured unemployment is 5 percent or greater and 120 percent or greater than the average of the rates of insured unemployment for the same week in the two immediately preceding calendar years.

b. When not paid. The state "off" indicator determines when extended benefits are not paid in this state. A state "off" indicator is in effect during a week for which the rate of insured unemployment is less than 5 percent or less than 120 percent of the average of the rates of insured unemployment for the same week in the two immediately preceding calendar years.

c. Period of payment. The extended benefit period is the period of time when extended benefits are paid in this state. An extended benefit period begins with the third week following a week for which there is a state "on" indicator in effect. An extended benefit period ends either with the completion of the thirteenth consecutive week beginning with the third week following a state "on" indicator, or later, with the completion of the third week following the first week for which there is a state "off" indicator. However, another extended benefit period shall not begin until the fourteenth week following the end of a previous extended benefit period.

d. Rate of insured unemployment. For the purposes of this subrule, the rate of insured unemployment means the percentage derived by dividing the average weekly number of individuals filing claims for regular benefits (excluding state plant closing benefits and benefits paid to federal civilian employees and ex-servicemembers under 5 U.S.C., chapter 85) in this state for weeks of unemployment with respect to the most recently completed 13-consecutive-week period by the average monthly insured employment for the first four of the six most recently completed calendar quarters immediately preceding the end of the 13-week period.

24.46(3) *Announcement and notice of the beginning and ending of an extended benefit period.*

a. Announcement by director. The beginning or ending date, whichever is appropriate, of an extended benefit period is announced by the director of the department of workforce development through appropriate news media in this state. As the case may be, the announcement clearly describes the unemployed individuals who may become eligible or ineligible for extended benefits.

b. Notice to individuals. The Form 65-5309, Notice to Individuals, is used by the department to notify individuals of:

(1) The beginning of an extended benefit period. The notice of potential entitlement to extended benefits is sent to each individual who has exhausted all rights to regular benefits either prior to the beginning of, or during, the extended benefit period and who has a benefit year which will not end prior to the beginning of the extended benefit. The notice describes those actions required of the individual to claim the extended benefits.

(2) The ending of an extended benefit period. The notice of termination of entitlement to extended benefits is sent to each individual who is currently filing a claim for extended benefits of the ending of an extended benefit period. The notice describes the effect on the individual's right to extended benefits.

24.46(4) *Amount and duration of extended benefits.*

a. Weekly extended benefit amount. An individual's weekly extended benefit amount paid for a week of total unemployment during the individual's eligibility period is equal to the individual's weekly regular benefit amount paid for a week of total unemployment during the individual's applicable benefit year.

b. Duration of extended benefits. The total amount of extended benefits which an individual may receive during the individual's applicable benefit year is limited to 50 percent of the total amount of regular benefits, excluding any state plant closing benefits, received by the individual during that benefit year or 13 times the individual's weekly regular benefit amount paid for a week of total unemployment during that benefit year whichever is less; however, an individual is limited to two weeks of extended benefits if the individual files an interstate claim for extended benefits in a state in which an extended benefit period is not in effect.

c. Eligibility period. The eligibility period is the period of weeks in and after an individual's benefit year which begin in an extended benefit period when an individual is eligible to receive extended benefits; however, if a benefit year ends within an individual's eligibility period for extended benefits, the remaining extended benefits which the individual is entitled to receive in that portion of the eligibility period which extends beyond the end of the individual's benefit year, is reduced, but not below zero, by an amount arrived at by multiplying the number of weeks of Federal Trade Readjustment Act benefits received by the individual during the benefit year times the individual's weekly extended benefit amount.

d. Applicable benefit year. The applicable benefit year includes the period of one year from the date that an individual files a valid claim for benefits and any weeks following this one-year period in which the individual's eligibility period for extended benefits has not expired and the individual is not able to establish a second benefit year for regular benefits.

24.46(5) *Eligibility requirements for extended benefits.* Except where the results are inconsistent with the provisions of the Federal-State Extended Unemployment Compensation Act of 1970 as amended and the Extended Benefit Program Regulations under 20 Code of Federal Regulations Part 615, the provisions of this state's law which apply to claims for, and the payment of, regular benefits apply to claims for, and the payment of, extended benefits. An individual is eligible to receive extended benefits for a week of unemployment during the individual's eligibility period if the department finds that all of the following conditions are met:

a. The individual is an exhaustee. An exhaustee is an individual who has exhausted all entitlements to regular benefits under this or any other state law as well as federal civilian employee, railroad unemployment insurance, and ex-servicemember benefits.

An individual is also an exhaustee:

(1) If the individual may be entitled to additional regular benefits as a result of a pending appeal with respect to wages that were not considered in the original monetary determination in the individual's benefit year.

(2) If the individual's benefit year has expired prior to the week, and the individual has no, or insufficient, wages on the basis of which to establish a new benefit year.

(3) If the individual has no right to benefits under other laws of the federal government, as specified in the regulations issued by the United States Secretary of Labor, or a contiguous country with which the United States has an agreement, but if the individual is seeking benefits and the appropriate agency finally determines that the individual is not entitled to the benefits, then the individual is an exhaustee.

b. The individual has one and one-half times the high quarter wages. An individual is required to have been paid wages for insured work during the individual's base period in an amount at least one and one-half times the wages paid to the individual during that quarter of the individual's base period in which the individual's wages were highest.

c. The individual is required to actively seek, apply for or accept, suitable work. When an individual files an initial claim for extended benefits, the Form 60-0274, Notice for Individuals Claiming

Extended Benefits, is used to determine the individual's prospects for obtaining work and to notify the individual that, beginning with the week following the week in which the individual is furnished this notice:

(1) If the individual's prospects for obtaining work within a reasonably short period are "good," the individual is required to actively seek, apply for or accept, suitable work in which, all other considerations being reasonably equal, the gross average weekly wage equals or exceeds 65 percent of the individual's average weekly wage from the highest earnings quarter of the individual's base period.

(2) If the individual's prospects for obtaining work within a reasonably short period are "not good," the individual is required to actively seek, apply for or accept, suitable work which is within the individual's capabilities to perform and which offers a gross average weekly wage which exceeds the individual's weekly extended benefit amount for a week of total unemployment plus any supplemental unemployment benefits; however, the individual is not required to actively seek, apply for or accept, work which offers a gross average weekly wage less than the federal or state minimum wage whichever is higher.

(3) For the purposes of this paragraph, reasonably short period means four weeks. If an individual whose prospects for obtaining work are "good" has not secured work within four weeks following the week in which the individual is furnished the Form 60-0274, Notice to Individuals Claiming Extended Benefits, then the individual is notified on Form 65-5309, Notice to Individuals, that the individual's prospects for obtaining work are now considered as "not good."

(4) For the purposes of this paragraph, actively seeking work means that, for each week following the week in which the individual is furnished the Form 60-0274, Notice to Individuals Claiming Extended Benefits, the individual is required to provide tangible evidence on the weekly claim for benefits that the individual is making a systematic and sustained effort to search for suitable work.

(5) If prospects are determined to be "not good," an individual shall not be disqualified for failing to apply for or accept work which is not offered in writing or is not listed with this state's employment service.

d. The individual is required to requalify following a disqualification for failure to actively seek, apply for or accept, suitable work. To become eligible for extended benefits following a disqualification for failure to actively seek, apply for or accept, suitable work, the individual is required to be employed in insured work for four weeks, which need not be consecutive, and earn four times the individual's weekly extended benefit amount.

871—24.47(96) Disaster benefits. Benefits under the Disaster Relief Act of 1974. Unemployment benefits payable under Public Law 93-288, the Disaster Relief Act of 1974, will be determined in accordance with the rules of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 625 and 650, and Chapter 32, Part 1710.16. These benefits are payable to claimants who are unemployed due to natural disasters. A claimant who is eligible for regular unemployment benefits shall not be eligible for disaster unemployment assistance.

871—24.48(96) UCFE claims. Benefits under the Federal Employer's Compensation Act. Unemployment benefits for civilian federal employees shall be determined in accordance with the applicable state law and rules as well as the rules of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 609, 615, 616, 617, and 650. These benefits are payable under the Federal Employer's Compensation Act, 5 U.S.C. 8101-8150, 8191-8193, and are based on wages earned by civilians in covered federal employment.

871—24.49(96) UCX claims. Benefits under the Ex-servicemember's Unemployment Compensation Act.

24.49(1) *Applicable law.* Unemployment benefits for ex-military personnel shall, in addition to being determined in accordance with applicable Iowa law and rules, be determined in substantial compliance with the rules and guidelines of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 614 and 650.

24.49(2) *When payable.* These benefits are payable under the Ex-servicemember's Unemployment Compensation Act of 1958, 5 U.S.C. 8850. They allow unemployment compensation to be based on wages earned while on active military duty.

871—24.50(96) Temporary extended unemployment compensation.

24.50(1) to **24.50(5)** Rescinded IAB 8/6/03, effective 9/10/03.

24.50(6) Overpayments will be offset up to and including 50 percent of the temporary extended unemployment compensation benefit payment.

24.50(7) Waiver of overpayments.

a. Individuals who have received amounts of temporary extended unemployment compensation to which they were not entitled shall be required to repay the amounts of such temporary extended unemployment compensation except that the state repayment may be waived if the workforce development department determines that:

(1) The payment of such temporary extended unemployment compensation was without fault on the part of the individual; and

(2) Such repayment would be contrary to equity and good conscience.

b. In determining whether fault exists, the following factors shall be considered:

(1) Whether a material statement or representation was made by the individual in connection with the application for temporary extended unemployment compensation that resulted in the overpayment and whether the individual knew or should have known that the statement or representation was inaccurate.

(2) Whether the individual failed or caused another to fail to disclose a material fact in connection with an application for temporary extended unemployment compensation that resulted in the overpayment and whether the individual knew or should have known that the fact was material.

(3) Whether the individual knew or could have been expected to know that the individual was not entitled to the temporary extended unemployment compensation payment.

(4) Whether, for any other reason, the overpayment resulted directly or indirectly, and partially or totally, from any act or omission of the individual or of which the individual had knowledge and which was erroneous or inaccurate or otherwise wrong.

c. In determining whether equity and good conscience exist, the following factors shall be considered:

(1) Whether the overpayment was the result of a decision on appeal;

(2) Whether the state agency had given notice to the individual that the individual may be required to repay the overpayment in the event of a reversal of the eligibility determination on appeal; and

(3) Whether recovery of the overpayment will cause financial hardship to the individual.

This rule is intended to implement Iowa Code sections 96.11 and 96.29.

871—24.51(96) School definitions.

24.51(1) Educational institution means public, nonprofit, private and parochial schools in which participants, trainees, or students are offered an organized course of study or training designed to transfer to them knowledge, skills, information, doctrines, attitudes or abilities from, by or under the guidance of an instructor or teacher. It is approved, licensed or issued a permit to operate as a school by the department of education or other government agency that is authorized within the state to approve, license or issue a permit for the operation of a school. The course of study or training which it offers may be academic, technical, trade, or preparation for gainful employment in a recognized occupation.

24.51(2) Educational service agency means a governmental agency or governmental entity which is established and operated exclusively for the purpose of providing educational services to one or more educational institutions.

24.51(3) Employment definitions.

a. Professional employees including educational service agency employees means persons who are employed in an instructional, research or principal administrative capacity as explained below:

(1) Instructional: Services performed for an educational institution which consist of teaching in formal classroom and seminar situations, tutoring, or lecturing in the activity of imparting knowledge; or of services which consist of directing or supervising the instructional activities of others; or services which consist of counseling, advising, or otherwise determining curriculum, courses, and academic pursuits for students.

(2) Research: Services performed for an educational institution which consist of careful and systematic study and investigation in a field of science and knowledge, undertaken to establish facts or principles. The work performed is in a predominantly intellectual field or artistic endeavor which is varied in character and requires the constant exercise of discretion and judgment in performance. The work further requires advanced knowledge in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study.

(3) Principal administrative: Services performed for an educational institution which consist of managing the educational institution or one of its major divisions or departments. Such services include the responsibility for establishing and administering policies, rules, and regulations which have major impact on the overall operations and functions of the educational institutions or one of its major divisions or departments. Work and activities are performed under general direction and broad objectives and missions, with the authority to determine goals and the techniques and methods of operations of the educational institution or one of its major divisions or departments. The duties performed by the individual rather than the title held should determine whether the prohibition applies. Neither providing a title nor withholding it should be controlling in itself.

b. Nonprofessional employees including educational service agency employees means persons who perform services in any capacity for an educational institution other than in an instructional, research, or principal administrative capacity.

24.51(4) Holiday recess. See vacation period subrule 24.51(8).

24.51(5) Institution of higher education means an educational institution which admits as regular students individuals having a certificate of graduation from a high school, or the recognized equivalent of such certificate; is legally authorized in this state primarily to provide a program of education beyond high school; provides an educational program for which it awards a bachelor's or higher degree or provides a program which is acceptable for full credit toward such a degree, a program of postgraduate or postdoctoral studies, or a program of training to prepare students for gainful employment in a recognized occupation; and is a public or other nonprofit institution.

24.51(6) Reasonable assurance, as applicable to an employee of an educational institution, means a written, verbal, or implied agreement that the employee will perform services in the same or similar capacity, which is not substantially less in economic terms and conditions, during the ensuing academic year or term. It need not be a formal written contract. To constitute a reasonable assurance of reemployment for the ensuing academic year or term, an individual must be notified of such reemployment.

24.51(7) School duration period.

a. Academic year is defined as that period of time that school personnel are obligated by contract to render services to the educational institution during the school year.

b. Term is defined as either of the two periods into which the yearly period of instruction is normally divided, commonly referred to as a semester. If the educational institution operates on a quarterly basis, then term shall mean the same as a quarter period. If the educational institution operates on a trimester basis, then term shall mean the same as a trimester period or any other division in a school year during which instruction is regularly given to students.

c. Twelve-month employment. School employees that perform services for educational institutions 12 months of a calendar year or years.

24.51(8) Vacation period or holiday recess. In Iowa Code section 96.4(5), the term "established and customary" vacation period or holiday recess involved in this provision includes those scheduled at Christmas and in the spring, when those vacation periods or recesses occur within a term.

24.51(9) Between terms or academic years denial means any week of unemployment which begins during the period between two successive academic years or during a similar period between two

regular terms, whether or not successive, or during a period of paid sabbatical leave provided for in the individual's contract, if the individual has a contract or reasonable assurance that the individual will perform services in any such capacity for any educational institution for both such terms or academic years.

871—24.52(96) Determining eligibility of school claims after employer protest.

24.52(1) Claim filed. When a claim has been filed by an employee of an educational institution, the department shall send a Form 65-5317, Notice of Claim, to the educational institution and such educational institution wishing to protest such a claim shall return such notice to the department and shall include on it a statement as to whether or not the individual who filed a claim had been given reasonable assurance for the ensuing academic year or term. The statement should include the date and method of such notification. A copy of the notification may be attached to Form 65-5317, Notice of Claim.

24.52(2) If the statement from the school indicates that there is no reasonable assurance of the employee returning to work for the ensuing academic year or term, the claim will be allowed, subject to meeting all other eligibility requirements. However, if an educational institution submits a statement or the claimant furnishes information concerning a reasonable assurance of school employment, the employee is subject to a denial of benefits. If the fact-finding should result in a disqualification, the effective starting date of the disqualification shall be determined as follows:

a. No earlier than the effective starting date of the claim as it would serve no useful purpose. If the job offer was prior to the beginning date of the claim and the claimant refuses the offer, the issue shall still be adjudicated since the issue is determined as a voluntary quit rather than a job refusal pursuant to subrules 24.25(37) and 24.26(19).

b. The Sunday of the week in which the job was offered under any of the following conditions:

(1) The employer protest was made within ten-day protest period.

(2) The department was notified within ten days of the date of the offer.

(3) The claimant was in a reporting status on a claim for unemployment insurance at the time the offer was made and the claimant failed to notify the department of the offer.

c. The Sunday of the week in which the claimant or employer notified this department of the offer unless the offer was prior to the week that the department was notified of the offer and the claimant was in reporting status on a claim for unemployment insurance at that time. In this situation, the effective starting date of disqualification shall be the Sunday of the week in which the job offer was made.

d. The Sunday of the week in which the employer notified the department of the offer to the claimant. A refusal to accept the offer of employment shall be adjudicated under the voluntary quit section of the law pursuant to subrules 24.25(37), 24.26(19) and 24.52(11).

24.52(3) Professional employee. Unemployment insurance payments which are based on school employment shall not be paid to a professional employee for any week of unemployment which begins between two successive academic years, between regular terms, or during a period of paid sabbatical leave if the individual has a contract or reasonable assurance to perform services in any such capacity for any educational institution for both such academic years or both such terms. However, unemployment insurance payments can be made which are based on non-school-related wage credits pursuant to subrule 24.52(6).

24.52(4) Nonprofessional employee.

a. Unemployment insurance payments which are based on school employment shall not be paid to a nonprofessional employee for any week of unemployment which begins between two successive academic years or terms if the individual has performed service in the first of such academic years or terms and there is a reasonable assurance that such individual will perform services for the second academic year or term. However, unemployment insurance payments can be made based on non-school-related wage credits pursuant to subrule 24.52(6).

b. The nonprofessional employee may qualify for retroactive unemployment insurance payments if the school employment fails to materialize in the following term or year and the individual has filed

weekly or biweekly claims on a current basis during the between terms denial period pursuant to subrule 24.2(1), paragraph *"e."*

24.52(5) Twelve-month, year-round employee. An educational institution employee who performs services on a 12-month, year-round basis whose employment is terminated through layoff or reduction in force prior to the completion of the 12-month period, is eligible for benefits and shall not be disqualified under the provisions of Iowa Code section 96.4(5). An offer of reemployment to the 12-month, year-round employee for the succeeding academic year or term shall be adjudicated under Iowa Code section 96.5(3), regarding offers of suitable work and no disqualification may be imposed prior to the week in which the employment is scheduled to commence.

24.52(6) Benefits which are denied to an individual that are based on services performed in an educational institution for periods between academic years or terms shall cause the denial of the use of such wage credits. However, if sufficient nonschool wage credits remain on the claim to qualify under Iowa Code section 96.4(4), the remaining wage credits may be used for benefit payments, if the individual is otherwise eligible.

24.52(7) Head start programs are considered educational in nature; however, the employing unit as a whole must have as its primary function the education of students. When the employing unit is operated primarily for educational purposes then the between terms denial established by Iowa Code section 96.4(5) will apply between two successive academic years or terms and will apply for holiday and vacation periods to deny benefits to school personnel.

a. A nonprofit organization which has as its primary function civic, philanthropic or public assistance purposes does not meet the definition of an educational institution. Community action programs which have a head start school as one component are not an educational institution employer and the between terms denial does not apply.

b. A head start program which is an integral part of a public school system conducted by a board of education establishes an employing unit whose primary function is educational; therefore, the between terms denial would apply.

24.52(8) Wages earned and payment deferred. Many school employees receive remuneration from their school employers on a 12-month basis for the 9-month period worked. Deductions from unemployment insurance payments are on a "when earned" basis rather than on a "when paid" basis. Deferred wages currently paid which are based on earnings from a prior period are not deductible on a current week claimed pursuant to Iowa Code section 96.19(9)*"b"* and paragraph 24.13(2)*"o."*

24.52(9) Vacation period and holiday recess. With respect to any services performed in any capacity while employed by an educational institution, unemployment insurance payments shall not be paid to any individual for any week which commences during an established and customary vacation period or holiday recess if such individual performs service in the period immediately before such vacation period or holiday recess and there is a reasonable assurance that such individual will perform service in the period immediately following such vacation period or holiday recess. However, the provision of subrule 24.52(6) could also apply in this situation.

24.52(10) Substitute teachers.

a. Substitute teachers are professional employees and would therefore be subject to the same limitations as other professional employees in regard to contracts, reasonable assurance provisions and the benefit denials between terms and during vacation periods.

b. Substitute teachers who are employed as on-call workers who hold themselves available for one employer and who will not search for or accept other work, are not available for work within the meaning of the law and are not eligible for unemployment insurance payments pursuant to subrule 24.22(2)*"i"*(1).

c. Substitute teachers whose wage credits in the base period consist exclusively of wages earned by performing on-call work are not considered to be unemployed persons pursuant to subrule 24.22(2)*"i"*(3).

d. However, substitute teachers engaged in on-call employment are not automatically disqualified but may be eligible pursuant to subrule 24.22(2)*"i"*(3) if they are:

(1) Able and available for work.

(2) Making an earnest and active search for work each week.

(3) Placing no restrictions on their employability.

(4) Show attachment to the labor market. Have wages other than on-call wages with an educational institution in the base period.

e. A substitute teacher who elects not to report for further possible assignment to work shall be considered to have voluntarily quit pursuant to subrule 24.26(19).

24.52(11) Declination of new contract or reasonable assurance.

a. The school employee who is not employed on a 12-month, year-round basis and who fails or refuses to accept a contract or reasonable assurance of employment in the succeeding academic term or year shall have the separation adjudicated under the voluntary quit provision of Iowa Code section 96.5(1) pursuant to subrule 24.25(37).

b. This subrule also applies to substitute teachers who fail or refuse to accept a contract or reasonable assurance of employment in the succeeding academic term or year pursuant to subrules 24.26(19) and 24.26(22).

24.52(12) Delayed offer and acceptance of a contract or reasonable assurance of employment in the succeeding term or year. School employees who are not offered a contract or reasonable assurance of employment in the succeeding academic term or year are eligible for benefits if all other eligibility conditions are met. However, school employees who subsequently receive a contract or reasonable assurance of employment for the following term or year shall be disqualified under the "between terms denial" provision.

24.52(13) Continuing supplemental (part-time) school employment after loss of nonschool employment. All employers, including employers of part-time workers are notified of the filing of a claim. The school employer who continues to furnish part-time employment to the claimant may make a protest on the basis that the individual is still employed at the part-time employment and request removal of any charges to the part-time employer account, whether contributory or reimbursable, pursuant to Iowa Code section 96.7(3)*"a"*(2).

871—24.53(96) Noncovered school-related employment.

24.53(1) Pursuant to rule 871—23.20(96), wages earned by a student who performs services in the employ of a school at which the student is enrolled and is regularly attending classes (either on a full-time or part-time basis) cannot be used as wage credits for claim or benefit purposes. However, wages earned by an individual who is a full-time employee for a school whose academic pursuit is incidental to the full-time employment may be used for claim and benefit purposes.

24.53(2) Pursuant to rule 871—23.20(96), wages earned by the spouse of such a student in employment with the educational institution attended by the student cannot be used for benefit purposes if the employee-spouse is told prior to commencing the employment that the work is part of a program to provide financial assistance to the student and is not covered by unemployment insurance.

24.53(3) Pursuant to rule 871—23.21(96), wages earned by a student who is enrolled at a nonprofit or public educational institution under a program taken for credit at such institution that combines academic instruction with work experience are normally excluded from the definition of employment. Provided, however, that work performed by such individual in excess of the hours called for in the contract between the school and the employer or performed in a period of time during which the institution is on a regularly scheduled vacation and for which such student receives no academic credit shall be considered as insured employment.

871—24.54(96) Church school coverage. Schools affiliated with a church are exempt from coverage but may volunteer coverage by request to the department of workforce development. Schools not affiliated with a church are covered employers with covered employment. Church school coverage is defined pursuant to rule 871—23.27(96).

871—24.55 and **24.56** Reserved.

871—24.57(96) Athletes—disqualifications. "Athletes" as used in Iowa Code section 96.5(9), is intended to apply to professional athletes. A professional athlete is an individual whose occupation is participating in athletic or sporting events for wages. A semiprofessional athlete is within the scope of Iowa Code section 96.5(9), if such sports services are compensation in covered wages. Auxiliary personnel, such as coaches, trainers, etc., are not considered professional athletes and are not within the scope of Iowa Code section 96.5(9).

24.57(1) As used in Iowa Code section 96.5(9), "any services, substantially all of which consist of participating in sports or athletic events" means all services performed by an individual in any subject employment during the individual's base year if such individual was engaged in remunerative sports or athletic events for 90 percent or more of the total time spent in subject employment during such base year.

24.57(2) As used in Iowa Code section 96.5(9), "participating in sports or athletic events" means any services performed in an athletic activity by an individual as:

a. A regular player or team member.

b. An alternate player or team member.

c. An individual in training to become a regular player or team member.

d. An individual who, although performing no active services, is retained as a player or team member while recuperating from illness or injury.

24.57(3) The beginning and ending dates of any sport season and the beginning and ending dates of the time period between two successive sport seasons shall be determined by the department after taking into consideration factors of custom and practice within a particular sport, published dates for beginning and ending of a season and any other information bearing upon such determination.

24.57(4) For the purposes of Iowa Code section 96.5(9), a reasonable assurance that an individual will perform services in sports or athletic events in a subsequent season is presumed to exist if:

a. The individual has an express or implied multiyear contract which extends into the subsequent sport season, or,

b. The individual is free to negotiate with other teams or employers for employment as a participant in the subsequent sport season, and

c. There is reason to believe that one or more employers of participants in athletic events is considering or would be desirous of employing the individual in an athletic capacity in the subsequent sport season, and

d. The individual has not clearly and affirmatively withdrawn from participating in remunerative and competitive sports or athletic events.

24.57(5) Benefits which will be paid with respect to weeks of unemployment during a sports season shall be based on all wage credits of the individual. Wage credits would include those earned in sports as well as in other employment covered by an employment security law. With respect to weeks of unemployment that begin during a period between sports seasons (or similar periods) no benefits are payable on the basis of any athletic or nonathletic wages if substantially all (see subrule 24.57(1)) of the services performed by the individual during the base period were in sports or athletic events.

24.57(6) When a professional athlete is denied benefits because there is a reasonable assurance that the individual will again perform services as a professional athlete in the next ensuing season but the assurance fails to materialize, the denial of benefits is effective until the date established that the assurance is ineffective. Following the ineffective date, benefits can be paid if the individual is otherwise eligible. If an assurance given to an individual is found to be not a bona fide assurance, benefits are payable if the individual is otherwise eligible.

24.57(7) Benefits will be paid with respect to weeks of unemployment between sports seasons (or similar periods) based on wage credits of the individual, paid in other employment covered by employment security law except those in sports or athletic events or training, or preparing to so participate.

24.57(8) Athletes—denial of benefits. An individual (athlete) will be denied benefits between seasons based on services performed by such individual (athlete).

This rule is intended to implement Iowa Code section 96.5(9).

871—24.58(96) Voluntary shared work. The voluntary shared work program provides that employers facing a temporary shortfall may reduce the work hours of employees in an affected unit and those employees will receive a portion of their regular unemployment insurance benefits. The program is designed to reduce unemployment and stabilize the workforce by allowing certain employees to collect unemployment insurance benefits if the employees share the work remaining after a reduction in the total number of hours of work and a corresponding reduction in wages. Additional information may be obtained by contacting the voluntary shared work coordinator. The employer may apply to participate in the program by completing a shared work plan application which must be approved by the department. The employer shall submit the plan to the department 30 days prior to the proposed implementation date. The employer will administer the program in cooperation with the department. Participating employees will complete the employee information form and claim for benefits and return them to the employer who will submit them to the department. Administrative penalties in force during the duration of the plan will make an employee ineligible for the program. Child support obligations will be deducted and unemployment insurance overpayments will be offset as they are for regular unemployment insurance benefits.

24.58(1) A shared work plan will last no longer than 52 weeks from the date on which the plan is first effective. The minimum length of a plan is four weeks.

24.58(2) Employment is considered seasonal if the production or service provided by the employment is curtailed by at least 45 percent or ceases for a four-month or longer period on an annual basis due to climatic conditions.

24.58(3) A plan which has been approved may be modified at the discretion of the department. An employer seeking modification of an approved plan must demonstrate good cause as to why the modification is necessary and must demonstrate that the factors necessitating the modification were not foreseeable at the time the plan was submitted.

24.58(4) Approval of a plan may be denied or revoked at the discretion of the department if the plan and its actual operation do not meet all the requirements stated in Iowa Code section 96.40 including, but not limited to, the providing of false or misleading information to the department, unequal treatment of any employee in the affected unit, a reduction in fringe benefits resulting from participation in the program, or failure by the employer to monitor and administer the program.

24.58(5) The employer may file in writing an appeal of a denial of approval of a plan or revocation of approval by the department within 30 days from the date the decision is issued. The employer's appeal will be forwarded to the appeals section so that a hearing may be scheduled before an administrative law judge.

24.58(6) If the employer provides as part of the plan a training program that will provide a substantive increase in the workplace and employability skills of the employee so as to reduce the potential for future periods of unemployment, the department shall consider the employee to be attending department-approved training and shall relieve the employer of charges for benefits paid to the individual attending training under the plan.

This rule is intended to implement 2009 Iowa Code Supplement section 96.40 as amended by 2010 Iowa Acts, Senate File 2279.

[**ARC 8711B**, IAB 5/5/10, effective 6/9/10]

871—24.59(96) Child support intercept. An individual who owes a child support obligation and who has been determined to be eligible for unemployment insurance benefits under Iowa Code chapter 96, shall have this information furnished to the child support recovery unit. The department of workforce development shall deduct and withhold from benefit payments the amount which is specified by the child support recovery unit. The term "benefits" for child support intercept purposes shall be defined as meaning any compensation payable under Iowa Code chapter 96, including any amounts payable pursuant to any workforce development agreement under any federal law administered by the department.

24.59(1) *Information furnished to child support recovery unit.* The department of workforce development shall furnish information to the child support recovery unit concerning all new claims

filed that are monetarily eligible for benefits under any state or federal program administered by the department.

24.59(2) *Action taken by child support recovery unit.* The child support recovery unit shall contact the claimant so that an opportunity is afforded to the claimant for a signed agreement to have a specified amount deducted and withheld from the claimant's benefits. The child support recovery unit shall submit a copy of the signed agreement to the department of workforce development and the department shall deduct and withhold the amount specified in the agreement.

24.59(3) *Garnishments.* Failure of the child support recovery unit to reach an agreement with the claimant for a specified amount to be deducted may result in the child support recovery unit initiating a garnishment action through legal process under Iowa Code chapter 642. The department of workforce development shall deduct and withhold from the claimant's benefits the amount specified. Notwithstanding section 96.15, benefits under chapter 96 are not exempt from garnishment, attachment, or execution if garnished by the child support recovery unit as established in Iowa Code section 252B.2, to satisfy the child support obligation of an individual who is eligible under this chapter. Child support obligation is defined as only those obligations which are enforced pursuant to the plan as described in Section 454 of the Social Security Act under Part D of Title IV entitled "State Plan for Child Support."

24.59(4) *Treatment of amount deducted for child support.* Any amount deducted from unemployment insurance payments for child support obligations shall be treated as if it were paid to the individual as benefits under Iowa Code chapter 96.

24.59(5) *Processing of payments.* The child support recovery unit shall furnish to the department the name and address of the designated public official to whom the amount deducted must be remitted. After the deduction, the remaining balance shall be credited to the claimant.

24.59(6) *Notice to claimant.* The department shall mail a notice to the claimant which explains the beginning date and the amount of the deduction from the claimant's weekly benefit amount which satisfies the individual's child support obligation to the child support recovery unit. This notice will be issued when the first deduction is made from the benefit payment. The notice shall explain the authority for the deduction and include the claimant's right of appeal.

24.59(7) *Appeal rights on the child support deduction.*

a. Any appeal on a child support deduction is limited to either the validity of workforce development's authority to make the deduction or the accuracy of the amount deducted.

b. The claimant will be advised to seek remedy either through the child support recovery unit or through the court system whenever the question of reasonableness or fairness of the deducted amount is raised in terms of ability to pay.

c. The department does not have the authority under Iowa Code chapter 96 to change the amount of the deduction as specified by garnishment or voluntary agreement or to adjudicate any appeal from garnishment or voluntary agreement.

This rule is intended to implement Iowa Code sections 96.3 and 96.20.

871—24.60(96) Alien. Any person who is not a citizen or a national of the United States. A national is defined as a person who lives in mandates or trust territories administered by the United States and owes permanent allegiance to the United States. An alien is a person owing allegiance to another country or government.

24.60(1) Section 3304(a)(14) of the Federal Unemployment Tax Act requires that the state law deny benefits which are based on services performed by an alien who has not been legally admitted to the country as a permanent resident. This provision does not deny benefits on the basis of services performed by noncitizens. It applies to services performed by individuals who do not have legal status of permanent residence in this country.

24.60(2) It is required that information designed to identify illegal nonresident aliens shall be requested of all claimants for benefits. This shall be accomplished by asking each claimant at the time the individual establishes a benefit year whether or not the individual is a citizen.

a. If the response is "yes," no further proof is necessary and the claimant's records are to be marked accordingly.

b. If the answer is "no," the claimant shall be requested to present documentary proof of legal residency. Any individual who does not show proof of legal residency at the time it is requested shall be disqualified from receiving benefits until such time as the required proof of the individual's status is brought to the local office. The principal documents showing legal entry for permanent residency are the Form I-94 "Arrival and Departure Record" and the Forms I-151 and I-551 "Alien Registration Receipt Card." These forms are issued by the Immigration and Naturalization Service and should be accepted unless the proof is clearly faulty or there are reasons to doubt their authenticity. An individual will be required to provide the individual's alien registration number at the time of claim filing.

c. Any or all documents presented to the department by an alien shall be subject to verification with the immigration and naturalization service. The citizenship question shall be included on the initial claim form so that the response will be subject to the provisions of rule 24.56(96), administrative penalties, and rule 871—25.10(96), prosecution on overpayments.

d. Rescinded IAB 8/6/03, effective 9/10/03.

24.60(3) Disqualification of aliens.

a. Aliens shall be disqualified for services performed unless such alien is an individual who:

(1) Was lawfully admitted for permanent residence at the time such services were performed or;

(2) Was lawfully present in this country for purpose of performing such service or;

(3) Was permanently residing in this country under color of law at the time such services were performed.

b. Color of law permanent residence is defined as:

(1) An alien admitted as a refugee under Section 207 of the Immigration and Nationality Act, 8 U.S.C. 1157, in effect after March 31, 1980;

(2) An alien granted asylum by the attorney general of the United States under Section 208 of the Immigration and Nationality Act, 8 U.S.C. 1158;

(3) An alien granted a parole into the United States for an indefinite period under Section 212(d)(5)(B) of the Immigration and Nationality Act, 8 U.S.C. 1182(d)(5)(B);

(4) Reserved.

(5) An alien who entered the United States prior to June 30, 1948, and who is eligible for lawful permanent residence pursuant to Section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259; or

(6) An alien who has been formally granted deferred action or nonpriority status by the immigration and naturalization service.

24.60(4) Certain nonimmigrants may perform service in this country. All nonimmigrant aliens 18 years and older are required by law to carry alien registration card Form I-94. The immigration and naturalization service places a symbol on the Form I-94 which indicates eligibility to perform service in this country.

a. Nonimmigrant aliens who are allowed to perform certain types of service are:

Class of worker		Symbol on I-94	Employment Permitted
(1)	Ambassador, Consular officers and their immediate families	A-1	May accept employment with permission from the Department of State and the Immigration Service. I-94 will be stamped: "Employment Authorized."
(2)	Other foreign government officials and their immediate families.	A-2	Same as for A-1.
(3)	Treaty trader, spouse and children Treaty investor, spouse and children	E-1 E-2	Admitted to work for a specific employer or as a sole proprietorship or partnership.

Class of worker		Symbol on I-94	Employment Permitted
(4)	Student	F-1 M-1	May accept employment of up to 20 hours per week with permission from the Immigration Service. I-94 will be stamped: "Employment Authorized." Employment should not displace a USC or permanent resident alien.
(5)	Representatives of foreign governments to international organization such as the U.N.	G-1 G-2 G-3 G-4 G-5	May accept employment if approved by the Department of State and the Immigration Service. I-94 will be stamped: "Employment Authorized."
(6)	Temporary worker of distinguished merit and ability	H-1	Are admitted to work on a petition of an employer. Can only work for that employer unless permission is granted by the Immigration Service to change employers.
(7)	Temporary workers performing services unavailable in the U.S.	H-2	Same as for H-1.
(8)	Trainee	H-3	Same as for H-1.
(9)	Exchange visitor Spouse and children	J-1 J-2	May be admitted to work in a specific program or may be granted permission to work after entry. I-94 will be stamped: "Employment Authorized."
(10)	Fiancé or fiancee of USC entering solely to conclude valid marriage Child of a K-1	K-1 K-2	May accept employment upon approval of the Immigration Service. I-94 will be stamped: "Employment Authorized."
(11)	Intra company transferee entering to continue employment with same employer. Dependents.	L-1 L-2	Admitted upon petition by an employer. May only work for that employer. May accept employment if approved by the Immigration Service. I-94 will be stamped: "Employment Authorized."
(12)	NATO representatives	NATO-1 NATO-2 NATO-3 NATO-4 NATO-5 NATO-6 NATO-7	Dependents may accept employment with approval of the Immigration Service. I-94 will be stamped: "Employment Authorized."

b. Immigrant aliens who are not allowed to perform services are:

Class of worker		Symbol on I-94	Employment Status
(1)	Attendant, servant or personal employee of an A-1 or A-2	A-3	May not accept employment.
(2)	Temporary visitor for business	B-1	May not accept employment.
(3)	Temporary visitor for pleasure	B-2	May not accept employment.
(4)	Alien in transit	C-1 C-2 C-3	May not accept employment.
(5)	Transit without a visa	TRWOV	May not accept employment.
(6)	Seaman	D-1 D-2	May not accept employment.
(7)	Dependent of student	F-2 M-2	May not accept employment.

Class of worker		Symbol on I-94	Employment Status
(8)	Spouse or child of an H-1, H-2 or H-3	H-4	May not accept employment.
(9)	Representative of foreign information media including spouse and children	I	May not accept employment.

This rule is intended to implement Iowa Code section 96.5(10).

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[1] See rule 345—4.50(96)

[2] Effective date of 24.26(14) and 24.26(15) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 8, 1999.

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