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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.

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Insurance Division[191]

Replace Chapter 10

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Replace Analysis

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Replace "V"

INSURANCE AGENTS
CHAPTER 10
LICENSING OF INSURANCE PRODUCERS

DIVISION I
LICENSING OF INSURANCE PRODUCERS

191—10.1(522B) Purpose and authority.

10.1(1) The purpose of these rules is to set out the requirements, procedures and fees relating to the qualification, licensure and appointment of insurance producers.

10.1(2) These rules are authorized by Iowa Code section 505.8 and are intended to implement Iowa Code chapters 252J, 261 and 522B.

191—10.2(522B) Definitions.

“Appointment” means a notification filed with the division or its designated vendor that an insurer has established an agency relationship with a producer. A company filing such a request must verify that the producer is licensed for the appropriate line(s) of authority.

“Birth month” means the month in which a producer was born.

“Business entity” means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“Commissioner” means the Iowa insurance commissioner.

“CSAC” means college student aid commission.

“CSRU” means child support recovery unit.

“Division” means the Iowa insurance division.

“Home state” means the District of Columbia and any state or territory of the United States in which a producer maintains the producer’s principal place of residence or principal place of business and is licensed to act as a producer.

“Individual” means a private or natural person, as distinguished from a partnership, corporation or association.

“Insurance” means any of the lines of insurance listed in subrule 10.7(1).

“License” means the division’s authorization for a person to act as a producer for the authorized lines of insurance.

“License number” means the National Insurance Producer Registry (NIPR) national producer number (NPN) issued to all licensees whose license records exist in the state producer licensing database (SPLD). For purposes of this definition, “state producer licensing database (SPLD)” means the national database of producers maintained by the National Association of Insurance Commissioners (NAIC), its affiliates or subsidiaries.

“National Insurance Producer Registry” or *“NIPR”* means the nonprofit affiliate of the National Association of Insurance Commissioners (NAIC). The NIPR’s Web site is www.NIPR.com.

“Negotiate” means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract provided that the person engaged in that act either sells insurance or obtains insurance for purchasers.

“NIPR Gateway” means the communication network developed and operated by NIPR that links state insurance regulators with the entities they regulate to facilitate the electronic exchange of producer information regarding license applications, license renewals, appointments and terminations.

“Nonresident” means a person whose home state is not Iowa.

“Notification” means a written or electronic communication from a producer to the division.

“Person” means an individual or a business entity.

“Producer” or *“insurance producer”* means a person required to be licensed in this state to sell, solicit or negotiate insurance.

“*Producer renewal notice*” means an electronic communication issued by the division to inform a producer about license renewal.

“*Resident*” means a person whose home state is Iowa.

“*Sell*” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

“*Solicit*” or “*solicitation*” means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

“*Termination*” means that an insurer has ended its agency relationship with a producer.

“*Termination for cause*” means that an insurer has ended its agency relationship with a producer for one of the reasons set forth in Iowa Code section 522B.11.

“*Uniform application*” means the National Association of Insurance Commissioners’ uniform application for resident and nonresident insurance producer licensing, as it appears on the NAIC Web site.

[ARC 7836B, IAB 6/3/09, effective 7/8/09]

191—10.3(522B) Requirement to hold a license.

10.3(1) No person may sell, solicit or negotiate insurance in Iowa until that person has been issued an Iowa producer license.

10.3(2) A person offering to the public, for a fee or commission, to engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages promised under any policy of insurance must be licensed as a producer.

10.3(3) A person shall not advise an Iowa resident to cancel, not renew, or otherwise change an existing insurance policy unless that person holds an Iowa producer license regarding the line of insurance for which the advice is given. This subrule shall not apply to a licensed attorney or certified public accountant who does not sell or solicit insurance.

10.3(4) The license itself does not provide the producer with any authority to represent or commit an insurer.

191—10.4(522B) Licensing of resident producers.

10.4(1) A person whose home state is Iowa and who desires to be licensed as a producer must satisfy the following requirements:

- a. Be at least 18 years of age,
- b. Have not committed any act that is grounds for denial under subrule 10.20(4).
- c. Submit a completed uniform application,
- d. Pass an examination in the line of authority sought, and
- e. Pay the appropriate producer license fee.

10.4(2) Examinations are conducted by the outside testing service on contract with the division. Applications and fees for examinations and for initial producer licensing will be submitted either to the outside testing service on contract with the division or as directed by the division. Instructions are available at the division’s Web site: www.iid.state.ia.us.

10.4(3) Reserved.

10.4(4) Examination results are valid for 90 days after the date of the test. Failure to apply for licensure within 90 days after the examination is passed shall void the examination results.

10.4(5) Amendments to producer licenses shall be done either by an outside vendor or by the division, as directed by the division. Any licensed producer desiring to become licensed in an additional line of authority shall:

a. Submit a completed uniform application form through the NIPR Gateway or as directed by the division, specifying the line(s) of authority requested to be added. Instructions are available at the division’s Web site: www.iid.state.ia.us; and

b. For each line of authority requested to be added, pass any required examination.

10.4(6) A producer who holds a personal lines authority can obtain property and casualty lines of authority upon successful completion of the commercial insurance subject examination.

10.4(7) To receive a license for excess and surplus lines, the applicant must have successfully completed the excess and surplus lines examination and also have successfully completed either: (1) the examinations for property and casualty lines of authority; or (2) the examination for personal lines of authority and the commercial insurance subject examination.

10.4(8) To receive a license for the variable products line of authority, the applicant must:

- a. Hold an active Iowa insurance license with a life insurance line of authority;
- b. Pass the Financial Industry Regulatory Authority (FINRA) examinations necessary to obtain an Iowa securities license; and
- c. File an application through the NIPR Gateway or as directed by the division to amend the license to add the variable products line of authority.

10.4(9) The division may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a producer license. If an applicant does not provide the additional information requested by the division within 45 days of receipt of the request, the application will expire and the license fee will not be returned.

191—10.5(522B) Licensing of nonresident producers.

10.5(1) A producer for whom Iowa is not the home state who desires to sell, solicit or negotiate insurance in Iowa must satisfy the following requirements to obtain an Iowa nonresident producer license:

- a. Be licensed and in good standing in the home state;
- b. Submit a proper request for licensure to the division through the NIPR Gateway; and
- c. Pay the appropriate fee.

10.5(2) Any licensed nonresident producer desiring to become licensed in an additional line of authority shall submit to the division using the NIPR Gateway a completed application form specifying the line(s) of authority requested to be added.

10.5(3) A license will not be issued to a nonresident producer if the producer's resident state does not issue licenses to Iowa resident producers applying for nonresident producer licenses in that state or if the producer's resident state restricts Iowa resident producers' nonresident activities in that state.

10.5(4) The division may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a producer license. If an applicant does not provide the additional information requested by the division within 45 days of receipt of the request, the application will expire and the license fee will not be returned.

191—10.6(522B) Issuance of license.

10.6(1) A person who meets the requirements of Iowa Code sections 522B.4 and 522B.5, or section 522B.7, and of rule 10.5(522B), unless otherwise denied licensure pursuant to Iowa Code section 522B.11 or rule 10.20(522B), shall be issued a producer license. A producer license shall remain in effect for an initial term of three years after the last day of the applicant's birth month of the year the license was issued, unless revoked or suspended. A license may be continually renewed pursuant to rule 10.8(522B) as long as the proper fees are paid and home state continuing education requirements are met. A renewal term is three years. If not renewed, a producer license automatically terminates on the last day of the month of the initial or renewal term.

10.6(2) An individual producer whose license has expired may seek reinstatement as set forth in rule 191—10.9(522B).

10.6(3) The license shall contain the producer's name, address, license number, date of issuance, date of expiration, the line(s) of authority held and any other information the division deems necessary. The license number shall be the same as the producer's National Insurance Producer Registry (NIPR) national producer number (NPN).

10.6(4) If the division issues or renews a producer license and subsequently determines that payment for the license or renewal was returned to the division by a bank without payment, or that the credit card

company does not approve or cancels or refuses amounts charged to the credit card, the license shall be immediately suspended until the payments are made and any fees or penalties charged by the division are paid, at which time the license may be reinstated. The individual may request a hearing within 30 days of receipt of notice by the division that the license was suspended.

191—10.7(522B) License lines of authority. In addition to the lines of authority listed in Iowa Code subsection 522B.6(2), the following lines of authority also are available for issuance in Iowa: crop; surety; and reciprocal (any other line of insurance issued in another state and for which Iowa grants authority to sell, solicit or negotiate in this state).

191—10.8(522B) License renewal.

10.8(1) Upon request by a producer, the division shall electronically transmit a producer renewal notice to a licensed producer at the producer's last-known electronic mail address as it appears in division records. If the division has received notification that the electronic address of record is no longer valid, no renewal notice will be transmitted.

10.8(2) A producer must apply for license renewal within 60 days prior to the expiration date of the license. Failure to apply to renew a license and pay appropriate fees prior to the expiration date of the license will result in expiration of the license.

10.8(3) A producer may submit an electronic mail address to the division as directed by the division.

10.8(4) Resident producer licenses may be renewed electronically through the NIPR Gateway at www.NIPR.com.

10.8(5) Nonresident producer licenses may be renewed only through the NIPR Gateway, or as otherwise directed by the division.

[ARC 7836B, IAB 6/3/09, effective 7/8/09]

191—10.9(522B) License reinstatement.

10.9(1) A resident producer may reinstate an expired license up to 12 months after the license expiration date by proving that during the CE term the producer met the CE requirements found in 191—Chapter 11, and by paying a reinstatement fee and license renewal fees. A resident producer who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

10.9(2) A nonresident producer may reinstate an expired license up to 12 months after the expiration date by submitting a request through the NIPR Gateway and by paying a reinstatement fee and license renewal fee. After the 12-month period, a nonresident producer must apply for a new license.

10.9(3) A producer who has surrendered a license for a nondisciplinary reason and stated an intent to exit the insurance business may file a request to reactivate the license. The request must be received at the division within 90 days of the date the license was placed on inactive status. The request will be granted if the former producer is otherwise eligible to receive the license. If the request is not received within 90 days, the producer must apply for a new license.

191—10.10(522B) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.

10.10(1) The term "reinstatement" as used in this rule means the reinstatement of a suspended license. The term "reissuance" as used in this rule means the issuance of a new license following either the revocation of a license or the forfeiture of a license in connection with a disciplinary matter, including but not limited to proceedings pursuant to rules 191—10.21(252J), 191—10.22(261) and 191—10.23(82GA,SF2428). This rule does not apply to the reinstatement of an expired license.

10.10(2) Any producer whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, may apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

a. All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license.

b. An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

c. A producer may request reinstatement of a suspended license prior to the end of the suspension term.

d. Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding paragraph 10.10(2) "c"), revocation, or acceptance of the forfeiture of a license.

10.10(3) All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such application shall be docketed in the original case in which the original license was suspended, revoked, or forfeited, if a case exists.

10.10(4) An order of reinstatement or reissuance shall be based upon a written decision which incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems desirable, which may include one or more of the types of disciplinary sanctions provided by Iowa Code section 522B.11. The order shall be a public record, available to the public, and may be disseminated in accordance with Iowa Code chapter 22.

10.10(5) A request for voluntary forfeiture of a license shall be made in writing to the commissioner. Forfeiture of a license is effective upon submission of the request unless a contested case proceeding is pending at the time the request is submitted. If a contested case proceeding is pending at the time of the request, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered disciplinary action and shall be published in the same manner as is applicable to any other form of disciplinary order.

10.10(6) When a producer's license has been suspended for a period of time which extends beyond the producer's license expiration date, the license will terminate at the license expiration date, and the producer must request reinstatement pursuant to subrule 10.10(2). If suspension for a period of time ends prior to the producer's license expiration date, the division shall reinstate the license at the end of the suspension period. The commissioner is not prohibited from bringing an additional immediate action if the producer has engaged in misconduct during the period of suspension.

191—10.11(522B) Temporary licenses. An Iowa resident may apply for a temporary license pursuant to Iowa Code section 522B.10. The applicant should submit a written request to the division which includes the reason for the request and the length of time for which the temporary license is requested. Temporary licenses will be issued for 90 days, with extensions allowed, but in no event for longer than 180 days, pursuant to Iowa Code section 522B.10.

191—10.12(522B) Change in name, address or state of residence.

10.12(1) If a producer's name is changed, the producer must file notification with the division within 30 days of the name change. The notification must include the producer's:

- a.* Prior name;
- b.* License number; and
- c.* New name.

Notification shall be filed through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.12(2) Address change. If a resident or nonresident producer's address is changed, the producer must file notification with the division within 30 days of the address change. The notification must include the producer's:

- a. Name;
- b. License number;
- c. Previous address; and
- d. New address. A producer may designate a business address instead of a resident address at the option of the producer.

Notification shall be filed through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.12(3) A nonresident producer who moves from one state to another state or an Iowa resident producer who moves to another state and wishes to retain an Iowa producer license must file a change of address with the division and provide a certification from the new resident state within 30 days of the change of legal residence. No fee or license application is required. If the new resident state is actively participating in the producer database, a letter of certification is not required. A nonresident licensed producer who moves to Iowa and wishes to retain the nonresident's producer license must file a change of address with the division within 90 days of the change of legal residence.

10.12(4) Issuance of an Iowa nonresident producer license is contingent on proper licensure in the nonresident producer's home state. Termination of the producer's resident license will be deemed termination of the Iowa nonresident producer license unless the producer timely files a change of address pursuant to this rule.

10.12(5) If a producer has provided an E-mail address to the division, the division has the option to send information to the producer through the E-mail address rather than through the mail.

191—10.13(522B) Reporting of actions.

10.13(1) A producer shall report to the division any actions required to be reported by Iowa Code section 522B.16.

10.13(2) A producer shall report to the division all CSAC or CSRU actions taken under or in connection with Iowa Code chapter 261 or 252J and all court orders entered in such actions.

10.13(3) Failure to file reports required by this rule is a violation of this chapter and will subject producers to penalty pursuant to rule 191—10.20(522B).

191—10.14(522B) Commissions and referral fees.

10.14(1) An insurance company shall not pay, and a person shall not accept, any commission, service fee, brokerage or other valuable consideration unless the person performing the service held a valid license for the line of insurance for which the service was rendered at the time the service was performed.

10.14(2) A producer may assign commissions to an entity organized for the purpose of operating that producer's insurance business if all of the entity's representatives who personally sell, solicit or negotiate insurance in Iowa are individually licensed as producers under Iowa law.

10.14(3) An insurer or a producer may pay a nominal fee for referrals if the same fee is paid for each referral whether or not the referral results in an insurance transaction.

10.14(4) An insurer or a producer may not charge an additional fee for services that are customarily associated with the sale, solicitation, negotiation and servicing of an insurance policy. This prohibition does not apply to assigned risk and commercial property/casualty policies. Any fees or other charges that are assessed to an insurance consumer must be fully disclosed.

10.14(5) A person who is not engaged in any activities in Iowa that require a producer license in Iowa is not required to maintain an active producer license in order to receive override or hierarchy commissions or to receive renewal commissions earned while the producer was actively engaged in activities that required a producer license.

191—10.15(522B) Appointments.

10.15(1) Insurers are required to file appointments with the division for each producer with which the producer has an agency relationship. The determination of whether an insurer and a producer have an agency relationship will be made by the division based on the totality of the circumstances surrounding the business relationship. Appointments are not issued for business entities.

10.15(2) Insurers shall file and pay for initial appointments using the NIPR Gateway, except that insurers authorized under Iowa Code chapter 518 or 518A shall file appointments directly with the division by arrangement with the division.

10.15(3) The notice of appointment must be filed within 30 days of the date the insurer and producer execute an agency contract or the first insurance application is submitted to the insurer.

10.15(4) Appointment fees are set forth in rule 191—10.26(522B). The division or its designee will electronically transmit a billing statement to insurers authorized under Iowa Code chapter 518 or 518A, and payment is due within 45 days. The division will assess a late fee of \$100 for the failure to timely pay appointment billing statements and an additional \$500 on or after the forty-sixth day.

10.15(5) The division may adopt special appointment filing procedures to allow an insurer to file one appointment request that will appoint a producer to some or all of the affiliated insurance companies that comprise a holding company.

10.15(6) When a company loses its identity in a new company by merger, acquisition, or otherwise, the new company must contact the licensing bureau to arrange for reappointment of the producers to the remaining company.

10.15(7) Insurance companies are required to file the name, address, and electronic address of a contact person for the company, to whom the billing statements will be sent. Insurance companies are required to notify the division if there is a change of the person appointed as the contact person or if a change of the address of such contact occurs. If a company fails to notify the division of such a change, the division shall charge the insurance company a \$100 fee.

[ARC 7836B, IAB 6/3/09, effective 7/8/09]

191—10.16(522B) Appointment renewal.

10.16(1) On or about December 1 of each year, the division or its designee will deliver reminders to insurance companies that appointment renewals are imminent. Appointments shall be renewed electronically via the NIPR Gateway at www.NIPR.com.

10.16(2) On or about January 2 of each year, a list of the producers currently appointed with each insurance company and a billing statement will be provided to each insurance company via the NIPR Gateway. The billing statement may not be altered, amended or used for appointing or terminating producers.

10.16(3) Payment is due on or before March 1.

10.16(4) Failure to pay renewal appointment fees by March 15 will result in termination of a company's appointments. Appointments that are terminated due to nonpayment of renewal fees may be reinstated upon payment of the renewal fee plus a reinstatement fee of \$500.

10.16(5) Insurance companies are required to file the name, address, and electronic address of a contact person for the company, to whom the appointment renewals will be sent. Insurance companies are required to notify the division if a change of the address of such contact occurs. If a company fails to notify the division of such a change of address, the division shall charge the insurance company a \$100 fee.

[ARC 7836B, IAB 6/3/09, effective 7/8/09]

191—10.17(522B) Appointment terminations.

10.17(1) When an insurance company terminates its relationship with a producer, the company shall notify the division using the NIPR Gateway. The termination must be filed within 30 days of the date the insurer terminated its agency relationship with the producer. The company shall also notify the producer that the producer's appointment has been canceled.

10.17(2) There is no fee for the filing of an appointment termination.

10.17(3) The division may adopt special procedures for the filing of termination requests for a group of affiliated insurance companies that comprise a holding company.

10.17(4) When an insurer terminates an appointment for cause pursuant to Iowa Code section 522B.14, the notification of termination may be filed according to subrule 10.17(1). The supporting documents required by Iowa Code section 522B.14 shall be submitted to the division within ten days

of the filing of the notification. The documents shall include a certification by an officer or authorized representative of the insurer.

191—10.18(522B) Licensing of a business entity.

10.18(1) Application. A business entity may apply for an Iowa insurance license. For purposes of this rule, upon approval of an application by the division, the business entity shall be classified as a producer and shall be subject to all standards of conduct and reporting requirements applicable to producers.

10.18(2) Requirements.

a. To qualify for such a license, the business entity must:

(1) File a completed NAIC uniform business entity application through the NIPR Gateway or as directed by the division. For purposes of this subrule, “uniform business entity application” means the National Association of Insurance Commissioners’ uniform business entity application for resident and nonresident business entities, as the application appears on the NAIC Web site;

(2) Designate one officer, owner, partner, or member of the business entity, which person also is a producer licensed by the division, as the person who will have full responsibility for the conduct of all business transactions of the business entity or of producers affiliated with the business entity;

(3) For a nonresident business entity, submit an appropriate request through the NIPR Gateway; and

(4) Pay the license fee.

b. The designated responsible producer shall maintain an active Iowa producer license. If the license of the designated responsible producer terminates or lapses for any reason, the business entity must supply the division with a substitute designated responsible producer within ten days. If the business entity does not provide a substitute, the division shall terminate the license, and the entity shall submit a new application.

10.18(3) License term. A business entity license issued under this rule shall be effective for three years and one month, including the year of application, beginning on the first day of the month of the business entity’s formation date and ending with the last day of the month of the business entity’s formation date. By arrangement with the division, a business entity may choose a different month for its license term.

10.18(4) License renewal. Upon request by a business entity, the division shall electronically transmit a renewal notice to the electronic mail address of the business entity on file with the division on or before the first day of the month preceding the renewal month. The renewal fee must be received by the division or its designated vendor on or before the license expiration date. All business entities must renew their licenses through the NIPR Gateway or as otherwise directed by the division.

10.18(5) Business address. Business entities licensed under this rule must maintain a current business address with the division. If a business entity’s address is changed, notification from the designated responsible producer must be submitted to the division within 30 days of the address change, stating:

- a.* Name of the business entity;
- b.* License number;
- c.* Previous address; and
- d.* New address.

The notification may be sent by electronic mail through the NIPR Gateway at www.NIPR.com, unless the division instructs the producer otherwise.

10.18(6) Business name. A business entity licensed under this rule must keep the division informed of its business name. If a business entity changes the name under which it is operating, notification from the designated responsible producer must be submitted to the division within 30 days of the name change. The notification may be sent by electronic mail to producer.licensing@iid.state.ia.us, or through the NIPR Gateway, if available.

[ARC 7836B, IAB 6/3/09, effective 7/8/09]

191—10.19(522B) Use of senior-specific certifications and professional designations in the sale of life insurance and annuities.

10.19(1) Purpose. The purpose of this rule is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

10.19(2) Scope. This rule shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by a producer.

10.19(3) Authority.

a. This rule is promulgated under the authority of Iowa Code chapters 507B and 522B.

b. Nothing in this rule shall limit the division's authority to enforce existing provisions of law.

10.19(4) Prohibited uses of senior-specific certifications and professional designations.

a. It is an unfair and deceptive act or practice in the business of insurance within the meaning of Iowa Code chapter 507B for a producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.

b. The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(1) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(2) Use of a nonexistent or self-conferred certification or professional designation;

(3) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the producer using the certification or designation does not have; and

(4) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

1. Is primarily engaged in the business of instruction in sales or marketing;

2. Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;

3. Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

4. Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

c. There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for purposes of subparagraph 10.19(4) "b"(4) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the organization or the certification or designation in question has been accredited by:

(1) The American National Standards Institute (ANSI);

(2) The National Commission for Certifying Agencies; or

(3) Any organization that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

d. In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

(1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

(2) The manner in which those words are combined.

e. Financial services regulatory agency.

(1) For purposes of this rule, a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

1. Indicates seniority or standing within the organization; or
2. Specifies an individual's area of specialization within the organization.

(2) For purposes of paragraph 10.19(4)“*e*,” “financial services regulatory agency” includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

f. Effective date. This rule shall become effective January 1, 2009.

191—10.20(522B) Violations and penalties.

10.20(1) A producer who sells, solicits or negotiates insurance, directly or indirectly, in violation of this chapter shall be deemed to be in violation of Iowa Code section 522B.2 and subject to the penalties provided in Iowa Code section 522B.17.

10.20(2) A person who sells, solicits or negotiates insurance, directly or indirectly, who is not properly licensed as a producer is subject to the penalties provided in Iowa Code chapter 507A and Iowa Code section 522B.17.

10.20(3) Any company or company representative who aids and abets a producer in the above-described violation shall be deemed to be in violation of Iowa Code section 522B.2 and subject to the penalties provided in Iowa Code section 522B.17.

10.20(4) The commissioner may place on probation, suspend, revoke, or refuse to issue or renew a producer's license or may levy a civil penalty, in accordance with Iowa Code section 522B.17 or any combination of actions, for any action listed in Iowa Code section 522B.11 and any one or more of the following causes:

a. Submitting to the division or to the outside testing service on contract with the division a check which is returned to the division by a bank without payment, or submitting a payment to the division by credit card which the credit card company does not approve, or canceling or refusing amounts charged to a credit card by the outside testing service on contract with the division where services were received by the producer;

b. Failing to report any administrative action or criminal prosecution taken against the producer or failure to report the termination of a resident producer license;

c. Acting as a producer through persons not licensed as producers; or

d. Taking any action to circumvent the spirit of these rules and the Iowa insurance statutes or any other action that shows noncompliance with the requirements of Iowa Code chapter 522B or these rules.

10.20(5) If a producer fails to provide to the division any notification required either by Iowa Code chapter 522B or by this chapter, including but not limited to notification of a change of address, notification of change of name, or notification of administrative criminal action as required by rules 191—10.12(522B) and 191—10.13(522B), within the required time, the producer shall pay a late fee of \$100. A business entity that fails to make a notification to the division as required by rule 191—10.18(522B) within the required time shall pay a late fee of \$100.

10.20(6) In the event that the division denies a request to renew a producer license or denies an application for a producer license, the commissioner shall provide written notification to the producer or applicant of the denial or failure to renew, including the reason therefor. The producer or applicant may request a hearing within 30 days of receipt of the notice to determine the reasonableness of the division's action. The hearing shall be held within 30 days of the date of the receipt of the written demand by the applicant and shall be held pursuant to 191—Chapter 3.

10.20(7) The commissioner may suspend, revoke, or refuse to issue the license of a business entity if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the entity and the violation was neither reported to the insurance division nor was corrective action taken.

191—10.21(252J) Suspension for failure to pay child support.

10.21(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent to the producer's last-known address by regular mail.

10.21(2) The notice shall contain the following items:

- a.* A statement that the commissioner intends to suspend the producer's application, request for renewal or current insurance license in 30 days.
- b.* A statement that the producer must contact the CSRU to request a withdrawal of the certificate of noncompliance;
- c.* A statement that the producer's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;
- d.* A statement that the producer does not have a right to a hearing before the division, but that the producer may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;
- e.* A statement that the filing of an application with the district court will stay the proceedings of the division;
- f.* A copy of the certificate of noncompliance.

10.21(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the division is notified by the district court of the resolution of the application.

10.21(4) If the division does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the division shall suspend the producer's application, request for renewal or current license 30 days after the notice is issued.

10.21(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt and the named producer shall be notified that the proceedings have been halted. If the producer's license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with division rules. All fees required for license renewal or license reinstatement must be paid by producers and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to this subrule.

191—10.22(261) Suspension for failure to pay student loan.

10.22(1) The division shall deny the issuance or renewal of a producer license upon receipt of a certificate of noncompliance from the college student aid commission (CSAC) according to the procedures set forth in Iowa Code sections 261.126 and 261.127. In addition to the procedures contained in those sections, this rule shall apply.

10.22(2) Upon receipt of a certificate of noncompliance from the CSAC according to the procedures set forth in Iowa Code sections 261.126 and 261.127, the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current license will be suspended 60 days after the date of the notice. Notice shall be sent to the producer's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed producer may accept service personally or through authorized counsel.

10.22(3) The notice shall contain the following items:

- a.* A statement that the commissioner intends to suspend the producer's application, request for renewal or current insurance license in 60 days;
- b.* A statement that the producer must contact the CSAC to request a withdrawal of the certificate of noncompliance;
- c.* A statement that the producer's application, request for renewal or current producer license will be suspended if the certificate of noncompliance is not withdrawn or, if the current license is on suspension, a statement that the producer's current producer license will be revoked;

d. A statement that the producer does not have a right to a hearing before the division, but that the producer may file an application for a hearing in district court pursuant to Iowa Code section 261.127;

e. A statement that the filing of an application with the district court will stay the proceedings of the division;

f. A copy of the certificate of noncompliance.

10.22(4) The effective date of revocation or suspension of a producer license, as specified in the notice required by Iowa Code section 261.126, shall be 60 days following service of the notice upon the applicant or registrant.

10.22(5) In the event an applicant or licensed producer timely files a district court action following service of a division notice pursuant to Iowa Code section 261.127, the division's suspension proceedings will be stayed until the division is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the division to proceed, the division shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a producer license, the division shall count the number of days before the action was filed and the number of days after the court disposed of the action.

10.22(6) If the division does not receive a withdrawal of the certificate of noncompliance from the CSAC or a notice from a clerk of court that an application for hearing has been filed, the division shall suspend the producer's application, request for renewal or current producer license 60 days after the notice is issued.

10.22(7) Upon receipt of a withdrawal of the certificate of noncompliance from the CSAC, suspension proceedings shall halt and the named producer shall be notified that the proceedings have been halted. If the producer's insurance license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with division rules. All fees required for license renewal or license reinstatement must be paid by producers and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code section 261.126.

10.22(8) The division shall notify the producer in writing through regular first-class mail, or such other means as the division deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a producer license, and shall similarly notify the producer when the producer license is reinstated following the division's receipt of a withdrawal of the certificate of noncompliance.

10.22(9) Notwithstanding any statutory confidentiality provision, the division may share information with the CSAC for the sole purpose of identifying producers subject to enforcement under Iowa Code chapter 261.

191—10.23(82GA,SF2428) Suspension for failure to pay state debt.

10.23(1) The commissioner shall deny the issuance or renewal of a producer license upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures in 2008 Iowa Acts, Senate File 2428. In addition to the procedures set forth in 2008 Iowa Acts, Senate File 2428, this rule shall apply.

10.23(2) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures set forth in 2008 Iowa Acts, Senate File 2428, the commissioner shall issue a notice to the producer that the producer's pending application for licensure, pending request for renewal, or current producer license will be suspended 60 days after the date of the notice. Notice shall be sent to the producer's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed producer may accept service personally or through authorized counsel.

10.23(3) Pursuant to 2008 Iowa Acts, Senate File 2428, section 14, the notice shall contain the following items:

a. A statement that the commissioner intends to suspend the producer's application, request for renewal or current producer license in 60 days;

b. A statement that the producer must contact the centralized collection unit of the department of revenue to schedule a conference or to otherwise obtain a withdrawal of the certificate of noncompliance;

c. A statement that the producer's application, request for renewal or current producer license will be suspended or denied if the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue within 60 days of the issuance of notice under this rule; or, if the current producer license is on suspension, a statement that the producer's current producer license will be revoked;

d. A statement that the producer does not have a right to a hearing before the commissioner, but that the producer may file an application for a hearing in district court pursuant to 2008 Iowa Acts, Senate File 2428, section 15;

e. A statement that the filing of an application with the district court will stay the proceedings of the commissioner;

f. A copy of the certificate of noncompliance.

10.23(4) Producers shall keep the commissioner informed of all court actions and all actions taken by the centralized collection unit of the department of revenue under or in connection with 2008 Iowa Acts, Senate File 2428; and producers shall provide to the commissioner, within seven days of filing or issuance, copies of all applications filed with the district court pursuant to 2008 Iowa Acts, Senate File 2428, section 15, of all court orders entered in such actions, and of all withdrawals of certificates of noncompliance by the centralized collection unit of the department of revenue.

10.23(5) The effective date of revocation or suspension of a producer license, as specified in the notice required by 2008 Iowa Acts, Senate File 2428, section 14, and subrule 10.23(2), shall be 60 days following service of the notice upon the applicant or producer.

10.23(6) In the event an applicant or licensed producer timely files a district court action following service of a notice by the commissioner pursuant to 2008 Iowa Acts, Senate File 2428, section 15, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date of the denial of the issuance or renewal of a producer license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

10.23(7) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the producer's application, request for renewal or current producer license 60 days after the notice is issued.

10.23(8) Upon receipt of a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue, suspension proceedings shall halt, and the named producer shall be notified that the proceedings have been halted. If the producer's license has already been suspended, the license shall be reinstated if the producer is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the producer, and all continuing education requirements must be met before a producer license will be renewed or reinstated after a license suspension or revocation pursuant to 2008 Iowa Acts, Senate File 2428.

10.23(9) The commissioner shall notify the producer in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a producer license, and shall similarly notify the producer when the producer license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

10.23(10) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the centralized collection unit of the department of revenue for the sole purpose of identifying producers subject to enforcement under 2008 Iowa Acts, Senate File 2428.

191—10.24(522B) Administration of examinations.

10.24(1) The division will enter into a contractual relationship with an outside testing service, in compliance with Iowa law, to provide the licensing examinations for all lines of authority which require an examination.

10.24(2) The outside testing service will administer all examinations for license applicants.

10.24(3) Any contract to implement subrule 10.24(1) shall require the outside testing service to:

- a. Update, on a continual basis, the licensing examinations;
- b. Ensure that the examinations are job-related;
- c. Adequately inform the applicants of the procedures and requirements for taking the licensing examinations;
- d. Prepare and administer examinations for all lines listed in Iowa Code subsection 522B.6(2) and rule 191—10.7(522B), except variable contracts; and
- e. Conform to division guidelines and Iowa law, and report to the division on at least a quarterly basis.

191—10.25(522B) Forms. An original of each form necessary for the producer's licensure, appointment and termination may be downloaded from the NAIC Web site, and the division's Web site (www.iid.state.ia.us) will provide a link to that site. Exact, readable, high-quality copies may be made therefrom. A self-addressed, stamped envelope must be submitted with each request.

191—10.26(522B) Fees.

10.26(1) Fees may be paid by check or credit card.

10.26(2) The fee for an examination shall be set by the outside testing service under contract with the division and approved by the division.

10.26(3) The fee for issuance or renewal of a producer license is \$50 for three years.

10.26(4) The fee for issuance or renewal of a business entity license is \$50 for three years.

10.26(5) The fee for reinstatement of a producer license is a total of the renewal fee plus \$100.

10.26(6) The fee for an appointment or the renewal of an appointment is \$5 for each producer appointed to a domestic company. The fee for appointment or renewal of each producer appointed to a foreign company is the fee charged by the state of domicile.

10.26(7) The division may charge a reasonable fee for the compilation and production of producer licensing records.

These rules are intended to implement Iowa Code chapters 252J, 261, and 522B and 2008 Iowa Acts, Senate File 2428.

191—10.27 to 10.50 Reserved.

DIVISION II
LICENSING OF CAR RENTAL COMPANIES AND EMPLOYEES
(Effective March 15, 2000)

191—10.51(522A) Purpose. The purpose of these rules is to govern the qualifications and procedures for the licensing of car rental companies and counter employees and to set out the requirements, procedures and fees relating to the qualification and licensure of car rental companies and counter employees.

191—10.52(522A) Definitions.

"Counter employee" means a person at least 18 years of age employed by a rental company that offers the products described in this chapter.

"Counter Employee Application" means the form used by an individual to apply for a counter employee license.

"Division" means the Iowa insurance division.

"Filed" means received at the Iowa insurance division.

“Limited Licensee Application” means the form used by a rental company to apply for a limited license.

“Rental company” means any person or entity in the business of primarily providing vehicles intended for the private transportation of passengers to the public under a rental agreement for a period not to exceed 90 days.

“Vehicle” means a motor vehicle under Iowa Code section 321.1 used for the private transportation of passengers, including passenger vans, minivans and sport utility vehicles or used for the transportation of cargo with a gross vehicle weight of less than 26,001 pounds and not requiring the operator to possess a commercial driver’s license, including cargo vans, pickup trucks and trucks.

191—10.53(522A) Requirement to hold a license.

10.53(1) A rental company that desires to offer or sell insurance in connection with the rental of a vehicle must file an application with the division and receive a license as a limited licensee.

10.53(2) A counter employee who desires to offer or sell insurance products must file an application with the division and receive a license as a counter employee.

191—10.54(522A) Limited licensee application process.

10.54(1) To obtain a limited licensee license, a person or entity must file a complete limited licensee application with the division and pay a fee of \$50 for a three-year license.

10.54(2) If the application is approved, the division will issue a limited licensee license.

191—10.55(522A) Counter employee licenses.

10.55(1) A person may not obtain a counter employee license unless that person is employed by a limited licensee.

10.55(2) To obtain a counter employee license, a person must file with the division a completed counter employee license application.

10.55(3) All persons who desire to obtain a counter employee license must first successfully complete an examination.

10.55(4) Examinations shall be administered by the limited licensee that employs the counter employee.

10.55(5) If the application is approved, the division will issue a three-year counter employee license. Applications are deemed approved if not disapproved by the division within 30 days of receipt at the division.

10.55(6) The counter employee license will automatically terminate when the counter employee ceases employment with a limited licensee.

191—10.56(522A) Duties of limited licensees.

10.56(1) A limited licensee is responsible for the training, examination and payment of license fees for all persons who desire to obtain a counter employee license with the limited licensee.

10.56(2) A limited licensee must obtain and administer an examination for all counter employee candidates. The content of the examination and the manner of its administration must be approved by the division.

10.56(3) The limited licensee must develop a system for examination content security.

10.56(4) The limited licensee must administer the counter employee examination under controlled conditions, approved by the division, that ensure that each candidate completes the examination without outside assistance or interference.

10.56(5) The limited licensee must notify the division of the termination of employment of any of its licensed counter employees. The limited licensee must file reports of terminations semiannually on July 1 and on January 1.

191—10.57(522A) License renewal.

10.57(1) All limited licensee and counter employee licenses will be issued with an expiration date of December 31 and must be renewed triennially.

10.57(2) A single renewal form for use in renewing the limited licensee's license and the licenses of all of its counter employees will be mailed to the limited licensee at its last-known address as shown on division records.

10.57(3) The limited licensee must complete and return the renewal form to the division on or before December 31 of the renewal year or all licenses listed on the renewal form will expire.

10.57(4) The fee for renewal of a limited licensee license is \$50 and the fee to renew each individual counter employee license is \$50.

191—10.58(522A) Limitation on fees. A limited licensee will not be required to pay more than \$1,000 in license or renewal fees in any one calendar year.

191—10.59(522A) Change in name or address.

10.59(1) Limited licensees must file written notification with the division of a change in name or address within 30 days of the change. This requirement applies to any change in any locations at which the limited licensee is doing business.

10.59(2) Limited licensees must file written notification with the division of a change in name or address of licensed counter employees. If the change of name is by a court order, a copy of the order must be included with the request. The limited licensee must file reports of name and address changes semiannually on July 1 and on January 1.

191—10.60(522A) Violations and penalties.

10.60(1) A rental company or counter employee that sells insurance in violation of this chapter shall be deemed to be in violation of Iowa Code Supplement chapter 522A and subject to the penalties provided in Iowa Code Supplement section 522A.3.

10.60(2) A limited licensee or licensed counter employee who commits an unfair or deceptive trade practice in violation of Iowa Code chapter 507B, or in violation of administrative rules adopted which implement that chapter, is subject to the penalties provided for in Iowa Code chapter 507B.

Rules 191—10.51(522A) to 191—10.60(522A) are intended to implement Iowa Code Supplement chapter 522A.

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◇ Two or more ARCs

UTILITIES DIVISION[199]

Former Commerce Commission[250] renamed Utilities Division[199]
under the “umbrella” of Commerce Department[181] by 1986 Iowa Acts, Senate File 2175, section 740.

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CHAPTER 22
RATES CHARGED AND SERVICE SUPPLIED BY TELEPHONE UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—22.1(476) General information.

22.1(1) *Application and purpose of rules.* The rules shall apply to any telephone utility operating within the state of Iowa subject to Iowa Code chapter 476, and shall supersede all conflicting rules of any telephone utility which were in force and effect prior to the adoption of their superseding rules. Unless otherwise indicated, “telephone utility” or “utility” shall mean both local exchange utility and alternative operator services company. These rules shall be construed in a manner consistent with their intent:

a. To allow fair competition in the public interest while ensuring the availability of safe and adequate communications service to the public.

b. To provide uniform, reasonable standards for communications service provided by telephone utilities.

c. To ensure that the provision of service of local exchange utilities and the charges of alternative operator services companies for communications service, and regulated services rendered in connection therewith, will be reasonable and just.

d. To ensure that no telephone utility shall unreasonably discriminate among different customers or service categories.

22.1(2) *Waiver and modification.* If unreasonable hardship to a utility or to a customer or user results from the application of any rule herein prescribed, application may be made to the board for the modification of the rule or for temporary or permanent exemption from its requirements.

The adoption of these rules shall in no way preclude the board from altering or amending them, pursuant to statute, or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

22.1(3) *Definitions.* For the administration and interpretation of these rules, the following words and terms shall have the meaning indicated below:

“*Active account*” refers to a customer who is currently receiving telephone service, or one whose service has been temporarily disconnected (vacation, nonpayment, storm damage, etc.).

“*Adjacent exchange service*” is local telephone service, including extended area service, provided to a customer via direct facility connection to an exchange contiguous to the exchange in which the customer is located.

“*Average busy-season, busy-hour traffic*” means the average traffic volume for the busy-season, busy-hours.

“*Base rate area*” means the developed portion or portions within each exchange service area as set forth in the telephone utility’s tariffs, maps or descriptions.

“*Board*” means the Iowa utilities board.

“*Business service*” means the service furnished to customers where the use is substantially of a business, professional, institutional, or occupational nature, rather than a social and domestic nature.

“*Busy-hour*” means the two consecutive half hours during which the greatest volume of traffic is handled in the office.

“*Busy-season*” means that period of the year during which the greatest volume of traffic is handled in the office.

“*Calls*” means telephone messages attempted by customers or users.

“*Central office*” means a unit in a telephone system which provides service to the general public, having the necessary equipment and operating arrangements for terminating and interconnecting customer lines and trunks or trunks only. There may be more than one central office in a building.

“*Central office access line*” means a circuit extending from the central office equipment to the demarcation point.

“*Channel*” means an electrical path suitable for the transmission of communications.

“*Check of service*” or “*service check*” means an examination, test or other method utilized to determine the condition of customer-provided terminal equipment and existing or new inside station wiring.

“*Class of service*” means the various categories of service generally available to customers, such as business or residence.

“*Competitive Local Exchange Carrier*” or “*CLEC*” means a utility, other than an incumbent local exchange carrier, that provides local exchange service pursuant to an authorized certificate of public convenience and necessity.

“*Customer*” means any person, firm, association, corporation, agency of the federal, state or local government, or legal entity responsible by law for payment for communication service from the telephone utility.

“*Customer provision*” means customer purchase or lease of terminal equipment or inside station wiring from the telephone company or from any other supplier.

“*Delinquent or delinquency*” means an account for which a bill or payment agreement for regulated services or equipment has not been paid in full on or before the last day for timely payment.

“*Demarcation point*” means the point of connection provided and maintained by the telephone utility to which inside station wiring becomes dedicated to an individual building or facility. For an individual dwelling, this point of connection will generally be immediately adjacent to, or within 12 inches of, the protector or the dwelling side of the protector. The drop and block, including the protector, will continue to be provided by and remain the property of the telephone utility. In the instance where a physical protector does not exist at the point of cable entrance into the building or facility, the demarcation point is defined as the entrance point of the cable into the building or facility.

“*Disconnect*” means the disabling of circuitry preventing both outgoing and incoming communications.

“*Due date*” means the last day for payment without unpaid amounts being subject to a late payment charge or additional collection efforts.

“*Exchange*” means a unit established by a telephone utility for the administration of communication services.

“*Exchange service*” means communication service furnished by means of exchange plant and facilities.

“*Exchange service area*” or “*exchange area*” means the general area in which the telephone utility holds itself out to furnish exchange telephone service.

“*Extended area service*” means telephone service, furnished at flat rates, between end user customers located within an exchange area and all of the end user customers of an additional exchange area. Extended area service is only for calls both originating and terminating within the defined extended area.

“*Foreign exchange service*” means exchange service furnished a customer from an exchange other than the exchange regularly serving the area in which the customer is located.

“*Former account*” refers to a customer whose service has been permanently disconnected, and the final bill either has been paid or has been written off to the reserve for uncollectible accounts.

“*Held order for primary service*” means an application for establishment of primary service to a local exchange utility using its existing facilities to provide service not filled within five business days of the customer-requested date, or within 15 business days of the customer-requested date, where no facilities are available. During the period a local exchange utility provides equivalent alternative service, the customer’s order for primary service shall not be considered a held order.

“*Held order for secondary service*” means an application for establishment of secondary service to a local exchange utility using its facilities to provide service not filled within 30 business days or the customer-requested date, whichever is later.

“*Inactive account*” refers to a customer whose service has been permanently disconnected and whose account has not been settled either by payment or refund.

“*Incumbent Local Exchange Carrier*” or “*ILEC*” means a utility, or successor to such utility, that was the historical provider of local exchange service pursuant to an authorized certificate of public

convenience and necessity within a specific geographic area described in maps approved by the board as of September 30, 1992.

“Interexchange service” is the provision of intrastate telecommunications services and facilities between local exchanges, and does not include EAS.

“Interexchange utility” means a utility, a resale carrier or other entity that provides intrastate telecommunications services and facilities between exchanges within Iowa, without regard to how such traffic is carried. A local exchange utility that provides exchange service may also be considered an interexchange utility.

“InterLATA toll service” means toll service that originates and terminates between local access transport areas.

“IntraLATA toll service” means toll service that originates and terminates within the same local access transport area.

“Intrastate access services” are services of telephone utilities which provide the capability to deliver intrastate telecommunications services which originate from end-users to interexchange utilities and the capability to deliver intrastate telecommunications services from interexchange utilities to end-users.

“Local exchange service” means telephone service furnished between customers or users located within an exchange area.

“Local exchange utility” means a telephone utility that provides local exchange service under tariff filed with the board. The utility may also provide other services and facilities such as access services.

“Message” means a completed telephone call by a customer or user.

“Message rate service” means service for which the customer charges are based on message units depending in part upon the number of originated local or extended area service messages.

“Outside plant” means the telephone equipment and facilities installed on, along, or under streets, alleys, highways, and private rights-of-way between customer locations, central offices or the central office and customer location.

“Percentage of fill” means the ratio of circuits and equipment in use to the total available multiplied by 100.

“Premises” means the space occupied by an individual customer in a building, in adjoining buildings occupied entirely by that customer, or on contiguous property occupied by the customer separated only by a public thoroughfare, a railroad right-of-way, or a natural barrier.

“Primary service” means the initial access to the public switched network.

“Protector” means a utility-owned electrical device located in the central office, at a customer’s premises or anywhere along any telephone facilities which protects both the telephone utility’s and the customer’s property and facilities from over-voltage and over-current by shunting such excessive voltage and currents to ground.

“Rate zone” means an area other than base rate area within an exchange service area where service generally is furnished at uniform rates without mileage charges.

“Rates” shall mean amounts billed to customers for local exchange service and alternative operator services.

“Rural service” means service in an exchange area outside of a base rate area or generally outside a special rate area.

“Secondary service” means services or facilities not classified as primary service.

“Special rate area” means an area within an exchange where service generally is furnished at uniform rates. Usually this comprises a developed area outside of the base rate area which is also known as a “locality rate area” and separated by some distance from the base rate area.

“Suspend” means temporary disconnection or impairment of service which shall disable either outgoing or incoming communications, or both.

“Switching service” means switching performed for service lines.

“Tariff” means the entire body of rates, classifications, rules, procedures, policies, etc., adopted and filed with the board by a telephone utility, including an alternative operator services company, in fulfilling its role of furnishing communications services.

“Telephone station” means the telephone instrument connected to the network.

“*Telephone utility*” or “*utility*” means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing communications service to the public for compensation.

“*Terminal equipment*” means all telephone instruments, including pay telephone equipment, the common equipment of large and small key and PBX systems and other devices and apparatus, and associated wirings, which are intended to be connected electrically, acoustically or inductively to the telecommunication system of the telephone utility.

“*Timely payment*” is a payment on a customer’s account made on or before the due date shown: (1) On a current bill for rates and charges, or (2) by an agreement between the customer and a utility for a series of partial payments to settle a delinquent account.

“*Toll connecting trunks*” means a general classification of trunks carrying toll traffic and ordinarily extending between a local office and a toll office.

“*Toll message*” means a message made between different exchange areas for which a charge is made, excluding message rate service charges.

“*Toll rate*” means the charge prescribed for toll messages, usually based upon the duration of the message, the distance between the exchanges, the day and time of the message and the degree of operator assistance.

“*Traffic*” means telephone call volume, based on number and duration of calls.

“*Traffic grade of service*” means the decimal fraction representing the probability of a call being blocked by an all-trunks-busy condition during the average busy-season, busy-hour.

“*Trouble report*” means any call or written statement from a customer or user of telephone service relating to a physical defect or to difficulty or dissatisfaction with the operation of telephone facilities.

22.1(4) Abbreviations.

AOS—Alternative Operator Services

EAS—Extended Area Service

PBX—Private Branch Exchange

22.1(5) Basic utility obligations. Each telephone utility shall provide telephone service to the public in its service area in accordance with its rules and tariffs on file with the board. Such service shall normally meet or exceed the standards set forth in these rules governing “Rates Charged and Service Supplied By Telephone Utilities.”

22.1(6) Deregulation actions.

a. The board, in the dockets shown in subparagraphs (1) to (14), deregulated the following services. Persons interested in determining the precise extent of deregulation in each docket should refer to the board dockets identified in this list. This list is provided for information only. Subsequent orders in these or other dockets may have modified the scope and manner of deregulation. Exclusion of an order or a statutory provision from this list in no way alters the effectiveness of such order or statutory provision.

(1) Inside station wiring including provisioning, repair, and maintenance. This included a revised definition of “demarcation point” in subrule 22.1(3). Docket No. RMU-81-19. Effective October 8, 1982.

(2) Terminal equipment including provision, installation, repair, and maintenance of all customer premises equipment. Docket No. RMU-82-1. Effective May 11, 1983.

(3) Centrex, Hi-Lo Capacity Intraexchange, and Hi Capacity Interexchange and Private Line. Docket No. RPU-84-8. Effective July 1, 1984.

(4) Coin-operated telephones. Pay telephones were determined to be a subset of deregulated terminal equipment. Docket Nos. RMU-85-6 and INU-84-6. Effective September 18, 1985.

(5) Riser cable (or cable for PBXs on the same premises) was found to be an extension of inside wiring. Ownership was transferred from the telephone utility to the premises owner. The telephone utility was compensated for the cable. Docket No. RMU-85-23. Effective April 30, 1986.

(6) Versanet Alarm Services Equipment. The remote module connecting an alarm panel to the local loop was determined to be deregulated terminal equipment. The Versanet equipment monitoring the signal was found to be competitive and deregulated. Docket No. INU-85-5. Effective May 16, 1986.

- (7) Mobile telephone and paging services. Docket No. INU-86-2. Effective August 7, 1986.
 - (8) Billing and collection services (but not the recording function). Docket Nos. RMU-86-16 and INU-86-10. Effective October 15, 1986.
 - (9) InterLATA Interexchange Message Telecommunications Service (MTS), Wide Area Telecommunications Service (WATS), Channel Service (Private Line), and Custom Network Service (Software Defined Network Service, Megacom Services, Megacom 800 Service, and AT&T Readyline Service). Docket No. INU-88-2. Effective April 5, 1989, and July 19, 1990.
 - (10) Speed calling. Docket No. INU-88-8. Effective December 22, 1989.
 - (11) The recording function of billing and collection services. Docket No. INU-88-9. Effective January 9, 1990.
 - (12) Competitive IntraLATA Interexchange Services, InterLATA and IntraLATA ISDN, Operator Services, Directory Services, and Voice Messaging Service. Docket No. INU-95-3. Effective June 24, 1996.
 - (13) Local directory assistance. Docket No. INU-00-3. Effective February 23, 2001.
 - (14) Local exchange services found to be competitive and deregulated in the following exchanges: Armstrong, Coon Rapids, Council Bluffs, Delmar, Forest City, Harlan, Laurens, Lowden, Mapleton, Oxford, Oxford Junction, Primghar, Saint Ansgar, Solon, Spencer, Stacyville, Stanwood, Storm Lake, Tiffin, and Whiting. Docket No. INU-04-1. Effective December 23, 2004.
- b.* Deregulation resulting from 2005 Iowa Acts, chapter 9, section 1. Effective July 1, 2005, Iowa Code section 476.1D(1) was amended to deregulate the retail rates for most business and residential local exchange services with the exception of single line flat-rated residential and business service rates, at the election of each telephone utility. The affected utilities opted for deregulation as follows:
- (1) Approval of Qwest Corporation's replacement tariff. Qwest's replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-167. Effective September 6, 2005.
 - (2) Approval of Frontier Communications of Iowa, Inc.'s replacement tariff. This replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-181. Effective September 20, 2005.
 - (3) Approval of Iowa Telecommunications Services, Inc.'s, d/b/a Iowa Telecom, replacement tariff. This replacement tariff removed the rates for most local exchange services, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-182. Effective November 5, 2005.
 - (4) Single line flat-rated residential and business service rates were found to be competitive and deregulated in the following exchanges: Alta, Belle Plaine, Bennett, Cambridge, Carter Lake, Greene, Grundy Center, Guthrie Center, Hartley, Manning, Marble Rock, Marengo, Onawa, Orange City, Osage, Oyens, Paullina, Reinbeck, Slater, and Wapello. Docket No. INU-05-2. Effective December 5, 2005.
 - (5) Single line flat-rated residential and business service rates were deregulated pursuant to Iowa Code section 476.1D(1). Docket No. INU-08-1. Effective July 1, 2008.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.2(476) Records and reports.

22.2(1) *Evaluation of records.* Each telephone utility has the obligation to continually study and evaluate its records and reports to ensure that any irregularities in service that may cause customer or user dissatisfaction or complaint are corrected expeditiously and that all phases of construction, equipment maintenance or operation are satisfactory.

22.2(2) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of Chapter 18 of the board's rules, Utility Records.

Where a telephone utility is operated in conjunction with any other enterprise, suitable records shall be maintained so that the results of the telephone operation may be determined upon reasonable notice and request by the board.

22.2(3) *Tariffs to be filed with the board.* The utility, including an alternative operator services company, shall file its tariff with the board, and shall maintain such tariff filing in a current status. A copy of the same tariff shall also be on file in all business offices of the telephone utility and shall be available for inspection by the public.

The tariff shall be classified, designated, arranged, and submitted so as to conform to the requirements of this chapter or board order. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification, and content of tariffs shall be in accordance with these rules unless otherwise provided.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not file schedules of rates unless required by another rule or by board order. Nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board. Every telephone utility shall make the schedule of its rates readily available to customers on the utility's Web site, if the utility has one, or by mail, upon request.

22.2(4) *Form and identification.* All tariffs shall conform to the following rules.

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½ x 11-inch sheets of white paper equal in durability to 20-pound bond paper with 25 percent cotton or rag content so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency, provided that the rules of the board as to title page; identity of superseding, replacing or revising sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue and effective date; and the words "Filed with the board" shall be applied to modify the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show in the order named:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Telephone Tariff
Filed with
Iowa Utilities Board

_____ (date)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on its title page that it is a revision of a tariff on file.

(3) When a revision or amendment is made to a filed tariff, the revision or amendment shall show on each sheet the designation of the original tariff or the number of the immediate preceding revision or amendment which it replaces. (See exhibit A)

(4) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly identify the part eliminated. (See exhibit A)

c. Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

(C)—Changed regulation

(D)—Discontinued rate or regulation

(I)—Increase in rate

(N)—New rate or regulation

(R)—Reduction in rate

(T)—Change in text only

d. All sheets except the title page shall have, in addition to the above-stated requirements, the following further information:

- (1) (Name of public utility) Telephone Tariff under which shall be set forth the words “Filed with board.” If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.
- (2) Issuing official and issue date.
- (3) Effective date (to be left blank by rate-regulated utilities).

EXHIBIT A

..... Telephone Tariff

(Name of Company)

Filed with board.

Part No.

..... Sheet No.

Canceling (or revising) Sheet No.

Amending Sheet No.

EXAMPLE

Issued Effective.....

(Date) (Date)

By

22.2(5) Content of tariffs.

- a. A table of contents listing tariff sections in the order in which they appear showing the sheet number of the first page of each rate schedule or other section. In the event the utility filing the tariff elects to segregate a section such as general rules from other sections, it may at its option prepare a separate table of contents or index for each such segregated section.
- b. Local exchange utilities shall file a map which shall clearly define the base rate boundary and any rural or special zones that are set forth in the tariff. The boundary line location on such maps shall be delineated from fixed reference points.
- c. The period during which the billed amount may be paid before the account becomes delinquent shall be specified. Where net and gross amounts are billed, the difference between net and gross is a late payment charge and the amount shall be specified.
- d. Forms of standard contracts required of customers for the various types of service available other than those which are defined elsewhere in the tariff.
- e. A designation, by exchange, of the EAS to other exchanges.
- f. The list of exchange areas served.
- g. Definitions of classes of customers.
- h. Extension rules, under which extensions of service will be made, indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included as required in 22.3(6).
- i. The type of construction which the utility requires the customer to provide if in excess of the Iowa electrical safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.
- j. Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and the terms upon which such construction will be permitted, with due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.
- k. Rules with which prospective customers must comply as a condition of receiving service.
- l. Notice by customer required for having service discontinued.
- m. Rules covering temporary service.
- n. Rules covering the type of equipment which may or may not be connected.

o. Rules on billing periods, bill issuance, notice of delinquency, refusal of service, service disconnection and reconnection and customer account termination for nonpayment of bill.

p. Rescinded IAB 12/21/05, effective 1/25/06.

q. Customer deposit rules which cover when deposits are required, how the amounts of required deposits are calculated, requests for additional deposits, interest on deposits, records maintained, issuance of receipts to customers, replacement of lost receipts, refunds and unclaimed deposit disposition.

r. A separate glossary of all acronyms and trade names used.

s. A general explanation of each regulated service offering available from the utility.

t. to v. Rescinded IAB 12/21/05, effective 1/25/06.

22.2(6) *Information to be filed with the board.*

a. Each utility shall file with the board the name, title, address, and telephone number of the person who is authorized to receive, act upon, and respond to communications from the board in connection with the following:

(1) General management duties.

(2) Customer relations (complaints).

(3) Engineering operations.

(4) Outages, including those occurring during nonoffice hours, pursuant to paragraph 22.2(8) “*d.*”

b. A copy of a new directory being distributed to customers.

22.2(7) *Universal service certification application.* Rescinded IAB 10/25/06, effective 11/29/06.

22.2(8) *Outage reporting requirements.* All communications providers included in 47 CFR § 4.3 (a), (c), (f), and (g) shall provide notification, outage reports, and current contact information as provided in this subrule.

a. Notification of reportable outage. All communications providers covered by this subrule shall notify the board of a reportable outage as defined in 47 CFR Part 4 by calling the board duty officer at 515-745-2332 or by sending an electronic message to the board duty officer at IUBDutyOfficer@iub.state.ia.us as soon as reasonably possible after discovering the outage, but no later than immediately after submitting the required electronic notification to the Federal Communications Commission (FCC). Notification to the board shall include a contact name and contact telephone number by which the board may immediately contact the reporting communications provider. A copy of the FCC notification shall be sent either by electronic mail to IUBDutyOfficer@iub.state.ia.us or by one paper copy, which shall be filed with the board.

b. Initial communications outage report. Immediately after submitting any initial communications outage report to the FCC (which is required to be submitted no later than 72 hours after an outage is discovered), all communications providers subject to this subrule shall send an electronic copy of the outage report to IUBDutyOfficer@iub.state.ia.us or file one paper copy of the report with the board.

c. Final communications outage report. Immediately after submitting any final communications outage report to the FCC (which is required to be submitted no later than 30 days after an outage is discovered), all communications providers covered by this subrule shall send an electronic copy of the final FCC report to IUBDutyOfficer@iub.state.ia.us or file one paper copy of any final communications outage report with the board.

d. Contact information required. In its annual report, every communications provider subject to this subrule shall submit to the board a current list of contact names and telephone numbers to be used when a service outage occurs or any other time the board or its staff requires immediate information, both during normal office hours and after normal office hours. The named individual(s) shall be knowledgeable about the technical aspects of a service outage(s), its estimated duration, the impact to customers, and the probable cause. Each communications provider shall update the board immediately whenever a change in the contact information occurs.

e. The information contained in the FCC notification and reports required to be filed pursuant to paragraphs 22.2(8) “*a*” to “*c*” shall be held as confidential pursuant to FCC order. The board may

provide general information or aggregate information from these reports when necessary for the public safety and welfare.

This rule is intended to implement Iowa Code section 476.2.
[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.3(476) General service requirements. The requirements of this rule do not apply to intrastate access service.

22.3(1) Directories. All directories published after the effective date of these rules shall conform to the following:

a. Telephone directories shall be published not less than annually, except for good cause shown, listing the name, address and telephone number of all customers unless otherwise requested by the customer. A local exchange carrier serving an exchange may choose not to publish a telephone directory if the local exchange carrier makes arrangements for publication in a directory that is commonly available in the local exchange in question.

b. Upon issuance, a copy of each directory shall be distributed without charge to all of the utility's customers locally served by that directory.

c. The year of issue or effective dates shall appear on the front cover and, if space permits, on the binding. Information pertaining to emergency calls, such as for the police and fire departments, for each exchange listed in the directory shall appear conspicuously on the front side of the first page of the directory. The directory shall also show a summary of the names of listed exchanges.

d. The directory shall contain such instructions concerning placing local and long distance calls, calls to repair and information services, and location of telephone company business offices as may be appropriate to the area served by the directory. A statement shall be included that the company will verify the condition of a line if requested by a customer and whether any charge will apply. The directory must indicate how to order 900 and 976 blocking and indicate that the first block is without charge. The directory shall contain descriptions of all current N11 services.

e. Directory assistance or intercept operators shall maintain records of all telephone numbers (except telephone numbers not listed or published at customer request) in the area for which they are responsible for furnishing information service.

f. In the event of an error or omission, in the name or number listing of a customer, that customer's correct name and telephone number shall be furnished to the calling party either upon request to or interception by the telephone company.

g. When additions or changes in plant, records, or operations which will necessitate a large group of number changes are scheduled, reasonable notice shall be given to all customers so affected even though the additions or changes may be coincident with a directory issue.

h. For any exchange in which an extended area call can terminate, the terminating exchange telephone utility shall provide all recently compiled directory listings, except listings for nonpublished or nonlisted customers, to the utility from which the extended area call originates. The telephone utility shall provide the directory listing without charge, within 30 days of receipt of a written request for those listings.

i. In addition to the serving exchange directory listing required under 22.3(1)“a,” upon the customer's request, an Iowa customer served by an out-of-state exchange shall be included in the directory list of one contiguous Iowa exchange of the customer's choice. Any charge for such Iowa listing shall be paid by the serving exchange.

22.3(2) Service check. Upon the individual customer's request, each telephone utility shall perform a service checkup to the demarcation point, without charge to the customer.

22.3(3) Class of service. Rescinded IAB 12/21/05, effective 1/25/06.

22.3(4) Compliance. Rescinded IAB 12/21/05, effective 1/25/06.

22.3(5) Pay telephone services and facilities. All telephone utilities shall make available to customers provisions for the interconnection of pay telephone equipment on the same basis as business service. A separate access line shall not be required for pay telephone equipment. Nonrate-regulated

telephone utilities shall provide service consistent with this subrule, but the subrule shall not apply to the pricing by nonrate-regulated telephone utilities of access lines to pay telephones.

22.3(6) Extension plan. Each utility shall develop a plan, acceptable to the board, for the extensions of facilities, where they are in excess of those included in the regular rates for service and for which the customer shall be required to pay all or part of the cost. The cost required to be paid by the customer shall be the revenue received by the telephone utility for the extension of plant and shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability. This plan must be related to the investment that prudently can be made for the probable revenue. No utility shall make or refuse to make any extensions except as permitted by the approved extension plan.

22.3(7) Reserved.

22.3(8) Traffic rules. Rescinded IAB 12/21/05, effective 1/25/06.

22.3(9) "Directory assistance." Rescinded IAB 12/21/05, effective 1/25/06.

22.3(10) Nonworking numbers. All nonworking numbers shall be placed upon an adequate intercept where existing equipment allows.

22.3(11) Assignment of numbers.

a. No telephone number shall be reassigned to a different customer within 60 days from the date of permanent disconnect.

b. For customers assigned a new number within the exchange, the former working number intercept shall provide the new number to a calling party for not less than 60 days or until the issuance of a new directory. No new number information shall be provided if the customer so requests.

EXCEPTION: When a change in number is required by a telephone utility due to nonpayment of yellow page advertising, the intercept is not required to volunteer the new number to callers. The new number shall be provided to callers of the directory assistance operator.

c. If the number assigned a customer results in wrong number calls sufficient in volume to be a nuisance, the number shall be changed at no charge.

22.3(12) Ordering and transferring of service. The terms and conditions for ordering and transferring local exchange service shall be contained in the telephone utility's tariff.

22.3(13) Basic local service. Rescinded IAB 12/21/05, effective 1/25/06.

22.3(14) Adjacent exchange service. All local exchange utilities shall file tariffs which include provisions which allow customers to establish adjacent exchange service.

a. The tariffs shall require the customer to pay the full cost of establishing and maintaining the adjacent exchange service.

b. In addition, the tariffs may include all or part of the following service provisions:

(1) The subscriber shall subscribe to local exchange service in the primary exchange in addition to the adjacent exchange service.

(2) All toll messages shall be placed through the primary exchange, unless there is a service outage in that exchange.

(3) The primary exchange company shall bill for the adjacent exchange service and make appropriate settlement to the secondary exchange company, unless the primary exchange and the adjacent exchange agree to a different billing arrangement.

(4) Adjacent exchange service shall be restricted to only the residential class of service, unless a waiver is permitted by the board for a particular customer for good cause shown.

(5) Failure of the subscriber to comply with the tariff provisions related to adjacent exchange service shall make the subscriber subject to discontinuance of service after appropriate notice.

c. These adjacent exchange service rules shall not affect the terms under which a customer receives adjacent exchange service, if that customer was receiving adjacent exchange service prior to the effective date of these rules.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.4(476) Customer relations.**22.4(1) Customer information.**

a. Each utility shall:

(1) Maintain up-to-date maps, plans, or records of its entire exchange systems. These maps shall be available for board examination at a location within Iowa during regular office hours and will be provided to the board upon request. These are not the same maps as the boundary maps described in subrule 22.20(3).

(2) Whenever a residential customer or prospective residential customer requests local exchange service from a utility, and the customer indicates a desire to be informed of the lowest priced service alternatives available for local exchange service, the utility shall inform that customer of the lowest priced alternative available from that utility, based only on monthly recurring rates for flat-rated services, at the relevant location.

(3) Notify customers affected by a change in rates or schedule classification.

(4) Furnish such additional information as the customer may reasonably request.

b. Inquiries for information or complaints to a utility shall be resolved promptly and courteously. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer.

Unless a customer agrees to an alternative form of notice, local exchange utilities shall notify their customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, the service may be subject to state regulation. You may request assistance from the Iowa Utilities Board, 350 Maple Street, Des Moines, Iowa 50319-0069, (515)281-3839 or toll-free 1-877-565-4450 or E-mail iubcustomer@iub.state.ia.us."

The bill insert or notice on the bill will be provided no less than annually. A telephone utility which provides local exchange service and issues an annual directory shall publish the information set forth above in its directory in addition to a mailing.

22.4(2) Customer deposits. Each utility may require from any customer or prospective customer a deposit intended to guarantee payment of bills for service based on the customer's credit history. No deposit other than for local exchange service is required to obtain local exchange service. The deposit must reflect the limits as to low-income customers in 199—subparagraph 39.3(2) "b"(4).

a. Deposits for local exchange service shall not be more in amount than the maximum charge for two months of local exchange service, or as may reasonably be required by the utility in cases involving service for short periods of time or special occasions. The deposit amounts must also reflect the limits as to low-income customers in 199—subparagraph 39.3(2) "b"(4).

b. Interest on customer deposits. Interest on such deposits shall be computed at 4.0 percent per annum, compounded annually. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

c. Each utility shall keep records to show:

(1) The name and address of each depositor.

(2) The amount and date of the deposit.

(3) Each transaction concerning the deposit.

d. Each utility shall issue a receipt of deposit to each customer from whom a deposit is received.

An itemized statement on the customer's bill may be considered an appropriate receipt. Each utility shall also provide means whereby a depositor may establish claim if the receipt is lost.

e. The deposit shall be refunded after not more than 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment). The account shall be reviewed after 12 months of service and if the deposit is retained it shall again be reviewed at the end of the utility's accounting year or on the anniversary date of the account.

f. Unclaimed deposits. The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

g. Unclaimed deposits, together with accrued interest, shall be credited to an appropriate account.

h. A new or additional deposit for local exchange service may be required to cover the amount provided in "a" above when a deposit has been refunded or the customer's payment history demonstrates a deposit is or continues to be appropriate. Written or verbal notice shall be provided advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of written or verbal notice to comply. The new or additional deposit may be payable electronically or by cash or check at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

i. A customer who fails to pay a new or additional deposit for local exchange service may be disconnected under the provisions of the written notice and 22.4(5).

22.4(3) *Customer billing, timely payment, late payment charges, payment and collection efforts.* Each utility's tariff rules shall comply with these minimum standards.

a. Billing to customers shall be scheduled monthly except upon mutual agreement of the customer and utility. A utility with unusual circumstances may obtain authority from the board for billing at other than monthly intervals.

b. Rescinded IAB 2/6/91, effective 3/13/91.

c. Paper bills shall be issued and delivered via U.S. mail unless the customer agrees to electronic or other billing pursuant to terms specified by tariff or customer agreement. Except as otherwise noted, the requirements of this subrule apply to both paper and electronic bills. The bill form or a bill insert shall provide the following information:

(1) The bill date and the bill due date for local exchange services, service charges, and other telecommunications services.

(2) The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered. For a paper bill, the bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. For an electronic bill, the bill shall be considered rendered to the customer on the date of transmission to the last-known E-mail address or as otherwise defined in an agreement between the customer and utility. If the delivery of a paper bill is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. If a bill cannot be transmitted electronically, the utility shall issue a paper bill. The utility may charge an appropriate amount for the distribution of a paper bill so long as the same amount is discounted should the customer choose electronic billing. When a customer changes from paper billing to electronic billing, the utility shall be allowed one complete billing cycle to make adjustments for electronic billing credits.

(3) Bills to customers shall be rendered regularly and shall contain a clear listing of all charges. A written, itemized listing of the services to which the customer subscribes and the monthly rates for those services shall be provided as part of the initial bill or when service is ordered and subsequently upon reasonable request of the customer.

(4) Each disconnection notice shall state that access to local exchange service shall not be denied for failure to pay for deregulated services.

(5) The requirements of subparagraph (1) above shall not apply to calls billed by interexchange utilities, including AOS companies.

(6) The requirements of subparagraphs (2), (3) and (4) above shall not apply to calls billed to a commercial credit card.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. Unless the terms of a multistate customer contract state otherwise, when the customer makes a partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall first be applied to the undisputed balance for local exchange service. If an amount remains, it may then be applied to other services.

f. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

g. All residential customers shall be permitted to have a last date for timely payment changeable for cause in writing; such as, but not limited to, 15 days following the approximate date each month upon which income is received by the person responsible for payment.

h. Maximum payment required for installation and activation of local exchange service shall comply with the total derived in accord with these rules and the filed tariff.

(1) An applicant for local exchange service, who under the tariff credit rules is required to make a deposit to guarantee payment of bills, may be required to pay the service charges and deposit prior to obtaining service.

(2) The amounts required must comply with 22.4(2), 22.4(5) and 22.4(7).

i. Maximum payments required by an active account or inactive account, for restoration of service of the same class and location as existed prior to disconnection, shall be the total of charges derived for reconnection and must comply with 22.4(2), 22.4(5) and 22.4(7). Only charges specified in the filed tariff shall be applied.

j. The utility may initiate collection efforts with the issuance of a final bill when the termination of service is at the customer's request. For all other bills no collection effort other than rendering of the bill shall be undertaken until the delinquency date.

k. Undercharges. The time period for which a utility may back bill a customer for undercharges shall not exceed five years unless otherwise ordered by the board.

l. Overcharges. The time period for which the utility is required to refund or credit the customer's bill shall not exceed five years unless otherwise ordered by the board. Refunds to current customers may be in the form of bill credits, unless the refund exceeds \$50 and the customer requests a refund in the same manner by which the bill was originally paid. Refunds to former customers may be made in the same manner by which the bill was originally paid. Refunds for local exchange service may not be applied to unpaid amounts for unregulated services.

22.4(4) Customer complaints.

a. Complaints concerning the charges, practices, facilities, or service of the utility shall be investigated promptly and thoroughly. The utility shall keep a record of such complaint showing the name and address of the complainant, the date and nature of the complaint, its disposition, and all other pertinent facts dealing with the complaint, which will enable the utility to review and analyze its procedure and actions. The records maintained by the utility under this rule shall be available for a period of two years for inspection by the board or its staff upon request.

b. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of all customer complaints.

c. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

d. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

22.4(5) Refusal or disconnection of service. Notice of a pending disconnection shall be rendered and local exchange service shall be refused or disconnected as set forth in the tariff. The notice of pending

disconnection required by these rules shall be a written notice setting forth the reason for the notice, and the final date by which the account is to be settled or specific action taken.

The notice shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The final date shall be not less than five days after the notice is rendered.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for refusal or disconnection of service. This notice shall include a toll-free or collect number where a utility representative qualified to provide additional information about the disconnection can be reached. The notice shall also state the final date by which the account is to be settled or other specific action taken. In determining the final date, the days of notice for the causes shall be concurrent.

Service may be refused or disconnected for any of the reasons listed below. Unless otherwise stated, the customer shall be provided notice of the pending disconnection and the rule violation which necessitates disconnection. Furthermore, unless otherwise stated, the customer shall be allowed a reasonable time in which to comply with the rule before service is disconnected. Except as provided in 22.4(5) "a," "b," "c," "d," and "e," no service shall be disconnected on the day preceding or the day on which the utility's local business office or local authorized agent is closed. Service may be refused or disconnected:

a. Without notice in the event of a condition on the customer's premises determined by the utility to be hazardous.

b. Without notice in the event of customer's use in such a manner as to adversely affect the utility's equipment or the utility's service to others.

c. Without notice in the event of tampering with equipment furnished and owned by the utility.

d. Without notice in the event of unauthorized use.

e. For violation of or noncompliance with the utility's rules on file with the board, the requirements of municipal ordinances or law pertaining to the service.

f. For failure of the customer or prospective customer to furnish service equipment, permits, certificates or rights-of-way specified to be furnished in the utility's rules filed with the board as conditions for obtaining service, or for the withdrawal of that same equipment or the termination of those permissions or rights, or for the failure of the customer or prospective customer to fulfill the contractual obligations imposed upon the customer as conditions of obtaining service by a contract filed with and subject to the regulatory authority of the board.

g. For failure of the customer to permit the utility reasonable access to its equipment.

h. For nonpayment of bill or deposit, except as restricted by 22.4(7), provided that the utility has made a reasonable attempt to effect collection and:

(1) Has provided the customer with 5 days' prior written notice with respect to an unpaid bill and 12 days' prior written notice with respect to an unpaid deposit, as required by this rule; disconnection may take place prior to the expiration of the 5-day unpaid bill notice period if the utility determines, from verifiable data, that usage during the 5-day notice period is so abnormally high that a risk of irreparable revenue loss is created.

(2) Is prepared to reconnect the same day if disconnection is scheduled for a weekend, holiday or after 2 p.m.

(3) In the event of a dispute concerning the bill, the telephone company may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill. Following payment of the undisputed amount, efforts to resolve the complaint, using complaint procedures in the company's tariff, shall continue and for not less than 45 days after the rendering of the disputed bill, the service shall not be disconnected for nonpayment of the disputed amount. The 45 days may be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board.

22.4(6) Medical emergency. Disconnection of a residential customer shall be postponed 30 days if an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered would present an especial danger to the health of any

permanent resident of the premises. Indicators of an especial danger to health include, but are not limited to: age; infirmity; mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstance which may indicate a severe or hazardous health situation. The telephone utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered, and a statement that the person is a resident of the premises in question. Initial verification may be by telephone, but the telephone utility may require a written verification within 5 days of the verification of the especial health danger by the physician or a public health official, including the name of the person endangered and a statement that the person is a resident of the premises in question. If the service has been disconnected within 14 days prior to verification of illness for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not make payment during the 30-day period, the service is then subject to disconnection pursuant to subrule 22.4(5).

22.4(7) *Insufficient reasons for refusal, suspension, or discontinuance of service.* The following shall not constitute sufficient cause for refusal, suspension, or discontinuance of local exchange service to a present or prospective customer:

- a. Delinquency in payment for service by a previous occupant of the premises to be served.
- b. Failure to pay for terminal equipment, inside station wiring or other merchandise purchased from the utility.
- c. Failure to pay for a different type or class of public utility service.
- d. Failure to pay the bill of another customer as guarantor thereof.
- e. Permitting another occupant of the premises access to the telephone utility service when that other occupant owed an uncollectible bill for service rendered at a different location.
- f. Failure to pay for yellow page advertising.
- g. Failure to pay for deregulated services other than local exchange service.

22.4(8) *Temporary service.* When the utility renders temporary service to a customer, it may require that the customer bear all the cost of installing and removing the service facilities in excess of any salvage realized.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.5(476) Telephone utility service standards.

22.5(1) *Requirement for good engineering practice.* The telephone plant of the utility shall be designed, constructed, installed, maintained and operated subject to the provisions of the Iowa electrical safety code as defined in 199 IAC Chapter 25 and in accordance with accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

22.5(2) *Adequacy of service.*

- a. Each local exchange utility and alternative operator services company shall employ prudent management and engineering practices so that sufficient equipment and adequate personnel are available at all times, including average busy-hour of the busy-season.
- b. Each local exchange utility and alternative operator services company shall conduct traffic studies, employ reasonable procedures for forecasting future service demand, and maintain records necessary to demonstrate to the board that sufficient equipment is in use and that an adequate operating force is provided.
- c. Each utility shall employ adequate procedures for assignment of facilities. The assignment record shall be kept up-to-date and checked periodically to determine if adjustments are necessary to maintain proper balance in all trunk and equipment groups. The records shall be available for review by the board upon request.
- d. The criteria established in these rules define a minimal acceptable standard for the most basic elements of telecommunications service. The rules do not include all criteria and they do not establish the most desirable service level for any basic element. If a specific element is not covered, the provider

must meet generally accepted industry standards for that element. Total service must also meet generally accepted industry standards.

e. The standards within these rules establish the minimum acceptable quality of service under normal operating conditions. They do not establish a level of performance to be achieved during the periods of emergency, catastrophe affecting large numbers of customers, nor do they apply to extraordinary or abnormal conditions of operation, such as those resulting from work stoppage, civil unrest, or other events.

22.5(3) Central office requirements.

a. Each local exchange utility shall employ appropriate procedures to determine the adequacy of central office equipment. Sufficient central office capacity and equipment shall be provided to meet the following minimum requirements during average busy-season, busy-hour:

- (1) Dial tone within three seconds for 98 percent of call attempts on the switched network.
- (2) Complete dialing of called numbers on at least 97 percent of telephone calls without encountering an all-trunks-busy condition within the central office.
- (3) At least 98 percent of all correctly dialed interoffice local calls shall not encounter an all-trunks-busy condition.
- (4) At least 98 percent of all correctly dialed calls offered to any trunk group within an EAS calling area will not encounter an all-trunks-busy condition.

b. Each local exchange utility shall engineer all central office equipment using sound engineering practice, consistent with the practices of the telephone industry. All new central offices shall be engineered on a terminal-per-station basis.

c. Rescinded IAB 6/3/09, effective 7/8/09.

d. Each central office shall be provided with alarms on a 24-hour basis to indicate improper functioning of equipment. All alarms shall be transmitted to an alarm center or to a location that will receive and respond to the alarm condition as set forth in the Utilities Emergency/Disaster Plan on a 24-hour, seven-day-a-week basis. All alarms and alarm sensors must be tested and reported internally on a regular basis, not to exceed six months.

22.5(4) Telecommunication circuits. All circuits shall be properly constructed and maintained to ensure quality service.

22.5(5) Interexchange trunks. Trunks for extended area service shall be provided so that at least 98 percent of telephone calls will not encounter an all-trunks-busy condition.

22.5(6) Loop transmission requirements. Local exchange utilities shall furnish and maintain adequate plant, equipment, and facilities to provide satisfactory transmission of communications between users in their service areas. Transmission shall be at adequate volume levels and free of excessive distortion. Levels of noise and cross talk shall be such as not to impair communications.

22.5(7) Minimum transmission objectives.

a. The transmission objectives set forth are based upon the use of standard telephone stations connected to a 48-volt dial central office, and measured at a frequency of 1,000 hertz.

b. Lines shall have a loop resistance not exceeding the operating design of the associated central office equipment, unless long line adapters and amplifiers or special equipment are used.

c. All loop measurements shall be taken across tip and ring and to ground at the demarcation point excluding all inside wiring and terminal equipment.

- (1) Loop current shall be acceptable above 20 mA.
- (2) Circuit loss shall be measured at 1004 KHz at 0 dBm from the central office. The acceptable level shall be 0 to—8 dBm with a maintenance margin not to exceed 8.5 dB.
- (3) Circuit noise shall be measured on a quiet (balanced) termination from the central office. The acceptable level shall be less than 20 dBrnC, the marginal level between 20 and 30 dBrnC, and unacceptable above 30 dBrnC.

(4) Power influence level shall be acceptable from 0 to 80 dBrnC, marginal from 80 to 90 dBrnC, and unacceptable above 90 dBrnC. Although the communication utility has the requirement to meet this objective, the communication and electric utilities shall cooperate in mitigating the effects of AC power induction.

d. Whenever feasible, the overall transmission loss, including terminating equipment, on intertandem trunks should be 6 dB for an all digital connection. Overall transmission loss, including terminating equipment on intertandem trunks should not exceed 9 dB for a composite digital and analog connection. This measurement shall be taken at 1004 Hz.

(1) The transmission objectives set forth are based upon measurements at the customer's network interface device with the customer premise disconnected.

(2) The transmission loss as set forth means the loss that occurs in a telecommunication connection measured in decibels (dB) at 1004 Hz exclusive of rest pads, impedance matching coils used for measuring and similar devices.

(3) A customer line shall, in general, have loop resistance not exceeding the operating design of the associated central office equipment. Amplifiers and long line adapters may be used to extend the central office design limits.

(4) A minimum line current of 20 mA DC is acceptable.

(5) The customer line (loop) shall be designed for a maximum loss of 8.0 dB at 1004 Hz to be measured from the customer demarcation to the central office one milliwatt test tone supply.

(6) The actual measured loss of the customer loop shall not exceed 9.0 dB from the customer demarcation to the central office one milliwatt test tone supply. A loss greater than 9.0 dB is unacceptable, requiring immediate action.

(7) Circuit noise is to be measured on a quiet termination from the central office. The acceptable level is not to exceed 20 dBrnC. The marginal level is between 20 dBrnC and 30 dBrnC. Any measurement exceeding 30 dBrnC is unacceptable, requiring immediate action.

22.5(8) *Joint use.* Where joint construction is mutually agreed upon, it shall be subject to the provisions of the Iowa electrical safety code and the requirement for good engineering practice found in subrule 22.5(1).

22.5(9) *Provisions for testing.* Each telephone utility shall provide or have access to test facilities which will enable it to determine the operating and transmission capabilities of circuit and switching equipment, either for routine maintenance or for fault location.

22.5(10) *Operator-assisted calls.* These operator services rules shall apply to all local exchange utilities, interexchange utilities, and alternative operator services companies which provide operator services.

a. All communications between customers must be considered as confidential in nature. The provider shall take reasonable action to minimize the potential access of other entities to those communications. Operators or employees of the provider must not listen to any conversation between customers except when an operating necessity. Operators shall not repeat or divulge the nature of any local or long distance conversation, nor divulge any information inadvertently overheard. Providers will be held responsible for strict compliance with this rule by their employees or other entities which perform this service for the provider.

b. Suitable rules and instructions shall be adopted by each provider and followed by employees or other entities employed by the provider governing the language and operating methods to be used by operators during assistance to customers. Any required call timing for regulated operator-assisted calls shall accurately record when the customer-requested connection is established and when it is terminated.

c. Each provider offering operator assistance to the public shall provide a service that can answer 90 percent of directory, intercept, toll, and local assistance calls within ten seconds. On the average, calls shall be answered within five seconds.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. An answer shall mean that the operator is ready to accept information necessary to process the call. An acknowledgment that the customer is waiting on the line shall not constitute an answer.

f. All operators receiving 0 - and 911 calls shall be capable of connecting calls to appropriate emergency services at all hours. All operator services providers shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

g. Third-party billing from identified public pay telephones and reverse charges from all telephones will be allowed:

- (1) If the person or device answering responds positively that the charges will be accepted, with the provision that remaining on the line does not constitute a positive response;
- (2) On reverse charges, when it is apparent the voice on the answering machine is the caller's voice; and
- (3) On a third-party billing, when it is apparent the voice on the answering machine at the billing number is the caller's voice.

22.5(11) Maintenance of plant and equipment.

a. Each telephone utility shall adopt and pursue a program of periodic inspection, testing, and preventive maintenance aimed at achieving efficient operation of its system to permit the rendering of safe, adequate and continuous service at all times.

b. Maintenance shall include keeping all plant and equipment in a good state of repair consistent with safe and adequate service performance. Broken, damaged or deteriorated parts which are no longer serviceable shall be repaired or replaced. Adjustable apparatus and equipment shall be readjusted promptly when found by preventive routines or fault location tests to be in unsatisfactory operating condition. Electrical faults, such as leakage or poor insulation, noise induction, cross talk, or poor transmission characteristics shall be promptly corrected to the extent practicable within the design capability of the plant affected when located or identified.

c. In all exchanges, periodic leakage tests shall be made on all circuits by use of proper instruments to determine that sufficient insulation is being maintained and further to discover any substantial change in insulation values which might cause future service difficulties. Loop resistance and transmission tests should be made on local circuits when transmission is poor, in an endeavor to locate the source of trouble.

d. Central office batteries shall be replaced when required to maintain good telephone service.

e. Central office equipment shall be inspected and routinely tested at regular intervals, and any necessary repairs, adjustments or replacements made to ensure the proper functioning of switching equipment.

f. All regulated outside plant facilities shall be properly maintained including replacement of equipment when broken, damaged, or when necessary for good transmission.

g. Records of various tests and inspections shall be kept on file in the office of the telephone utility for a minimum of one year. These records shall show the line or regulated equipment tested or inspected, the reason for the test, the general conditions under which the test was made, the general result of the test, and any corrections made.

22.5(12) Reserved.

22.5(13) Terminating access blocking. Rescinded IAB 12/21/05, effective 1/25/06.

22.5(14) Information service access blocking. Each local exchange utility shall include in its tariff on file with the board a provision giving its subscribers the option of blocking access to all 900 and 976 prefix numbers, without charge for the first block.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.6(476) Standards of quality of service. The local exchange utility using its facilities to provide primary service will measure its service connection, held order, and service interruption performance monthly according to subrules 22.6(1), 22.6(2), and 22.6(3). Records of the measurements and any summaries thereof, by individual wire centers, will be provided upon request of the board. Records of these measurements will be retained by the utility for two years.

22.6(1) Service connection. Each local exchange utility using its facilities to provide service shall make all reasonable efforts to maintain a five-business-day standard for primary connection service or within the customer-requested service connection date. All reasonable efforts to maintain the above standard shall be measured by the following:

a. Eighty-five percent of all customers provided service within five business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

b. Ninety-five percent of all customers provided service within ten business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

c. Ninety-nine percent of all customers provided service within 30 business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

22.6(2) Held orders.

a. During such period of time as a local exchange utility using its facilities to provide service may not be able to supply primary telephone service to prospective customers within five business days after the date applicant desires service, the telephone utility shall keep a record, by exchanges, showing the name and address of each applicant for service, the date of application, the date that service was requested, and the class of service applied for, together with the reason for the inability to provide new service to the applicant.

b. When, because of a shortage of facilities, a utility is unable to supply primary telephone service on the date requested by applicants, first priority shall be given to furnishing those services which are essential to public health and safety. In cases of prolonged shortage or other emergency, the board may require establishment of a priority plan, subject to its approval for clearing held orders, and may request periodic reports concerning the progress being made.

c. When the local exchange utility using its facilities to provide service fails to provide primary local exchange service to any customer requesting service within 15 business days, the local exchange utility shall provide the customer with an alternative form of service until primary local exchange service can be provided. The alternative form of service provided shall be wireless telephone service unless the customer agrees otherwise.

d. If an alternative form of primary service is provided, the local exchange utility is authorized to charge the customer the regular rates (if applicable) for the alternative primary service ordered, if such rates are less than the regulated rate for primary local exchange service. Otherwise, the customer will be charged the regulated rate for primary local exchange service. Where an alternative form of service is impossible to provide, the facilities-based local exchange utility shall waive all usual installation charges and, once primary local exchange service is provided, shall credit the customer's account in an amount equal to the pro-rata monthly primary local exchange charge for each day service was not provided.

22.6(3) Service interruption.

a. Each telephone utility using its facilities to provide primary service shall make all reasonable efforts to prevent interruptions of service. When interruptions are reported or found by the utility to occur, the utility shall reestablish service with the shortest possible delay. Priority shall be given to a residential customer who states that telephone service is essential due to an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered. All reasonable efforts shall be measured by the following:

(1) Eighty-five percent of all out-of-service trouble reports cleared within 24 hours. Compliance will be measured based on a three-month rolling average.

(2) Ninety-five percent of all out-of-service trouble reports cleared within 48 hours. Compliance will be measured based on a three-month rolling average.

(3) One hundred percent of all out-of-service trouble reports cleared within 72 hours.

(4) The response time for all utilities responsible to test and attempt to correct any interexchange trunk problem, except a total outage, shall be within 24 hours after the problem is reported. If the problem is not corrected within that time, the utility responsible for doing so shall keep all other affected telephone utilities advised as to the current status on a daily basis. For a total outage, the response time shall be immediate.

b. Arrangements shall be made to have adequate personnel and equipment available to receive and record trouble reports and also to clear trouble of an emergency nature at all times.

c. Calls directed to the published telephone numbers for service repair or the business offices of the telephone utility shall be acknowledged within 20 seconds for 85 percent of all such calls and within 40 seconds for 100 percent of all such calls.

d. If a customer's service must be interrupted due to maintenance, the utility shall notify the affected customer, in advance, if possible. The company shall perform the work to minimize inconvenience to the customer and strive to avoid interruptions when there is conversation on the line.

e. Each telephone utility shall keep a written record showing all interruptions affecting service in a major portion of an exchange area for a minimum of six years. This record shall show the date, time, duration, time cleared and extent and cause of the interruption. This record shall be available to the board upon request.

f. Whenever a trouble report is received, a record shall be made by the company and if repeated within a 30-day period by the same customer, the case shall be referred to an individual for permanent correction.

g. When a customer's service is reported or is found to be out of order, it shall be restored as promptly as possible.

h. Each local exchange utility using its facilities to provide service shall maintain its network to reasonably minimize customer trouble reports. The rate of customer trouble reports on the company side of the demarcation point will not exceed four per 100 access lines per month per wire center.

i. When a subscriber's service is interrupted and remains out of service for more than 24 consecutive hours after being reported to the local exchange company or being found by the company to be out of order, whichever occurs first, the company shall make appropriate adjustments to the subscriber's account. This rule does not apply if the outage occurs as a result of:

- (1) A negligent or willful act on the part of the subscriber;
- (2) A malfunction of subscriber-owned telephone equipment;
- (3) Disasters or acts of God; or
- (4) The inability of the company to gain access to the subscriber's premises.

The adjustment, either a direct payment or a bill credit, shall be the proportionate part of the monthly charges for all services and facilities rendered inoperative during the interruption. The adjustment shall begin with the hour of the report or discovery of the interruption. Adjustments not in dispute shall be rendered within two billing periods after the billing period in which the interruption occurred.

22.6(4) Repair—missed appointments. When a utility makes an appointment for installation or repair within a given range of time, and misses that appointment by over an hour, the customer will receive one month's primary local service free of charge. This is applicable to each missed appointment.

22.6(5) Emergency operation.

a. Each telephone utility shall make reasonable provisions to meet emergencies resulting from failures of power service, climate control, sudden and prolonged increases in traffic, illness of operators, or from fire, explosion, water, storm, or acts of God, and each telephone utility shall inform affected employees, at regular intervals not to exceed one year, of procedures to be followed in the event of emergency in order to prevent or mitigate interruption or impairment of telephone service.

b. All central offices shall have adequate provision for emergency power. Each central office shall contain a minimum of two hours of battery reserve. For offices without permanently installed emergency power facilities, there shall be access to a mobile power unit with enough capacity to carry the load which can be delivered on reasonably short notice and which can be readily connected.

c. An auxiliary power unit shall be permanently installed in all toll centers and at all exchanges exceeding 4,000 access lines.

d. Each local exchange utility shall maintain and make available for board inspection, its current plans for emergency operations, including the names and telephone numbers of the local exchange utility's disaster services coordinator and alternates.

22.6(6) Business offices.

a. Each local exchange utility shall have one or more business offices or customer service centers staffed to provide customer access in person or by telephone to qualified personnel, including supervisory personnel where warranted, to provide information relating to services and rates, accept and process

applications for service, explain charges on customers' bills, adjust charges made in error, and, generally, to act as representatives of the local exchange utility. If one business office serves several exchanges, toll-free calling from those exchanges to that office shall be provided.

b. Upon the closing of any local exchange utility's public business office, the company must provide to the board, in writing, at least 30 days prior to the closing of the office the following information:

- (1) The exchange(s) and communities affected by the closing;
- (2) The date of the closing;
- (3) A listing of other methods and facility locations available for payment of subscribers' bills in the affected exchanges; and
- (4) A listing of other methods and locations available for obtaining public business office services.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.7(476) Safety.

22.7(1) Protective measures.

a. Each utility shall exercise reasonable care to reduce the hazards to which its employees, its customers or users and the general public may be subjected.

b. The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

c. Each utility shall maintain a summary of all reportable accidents arising from its operations.

22.7(2) Safety program. Each utility shall adopt and execute a safety program, fitted to the size and type of its operations. As a minimum, the safety program should:

- a.* Require employees to use suitable tools and equipment in order that they may perform their work in a safe manner.
- b.* Instruct employees in safe methods of performing their work.
- c.* Instruct employees who, in the course of their work, are subject to the hazard of electrical shock, asphyxiation or drowning, in accepted methods of artificial respiration.

199—22.8(476) Nontoll interexchange trunking service (EAS) survey procedure.

22.8(1) General information.

a. The nontoll interexchange trunking service (EAS) survey procedures shall be followed by all telephone companies subject to the service jurisdiction of this board. The procedures in 22.8(2) and 22.8(3) shall be followed to establish EAS. The procedures in 22.8(4) and 22.8(5) shall be followed in order to discontinue EAS. There is no need to follow these procedures if there will be no rate increase associated with new EAS.

b. At all stages of this procedure the information required to be supplied to customers shall be sufficient to explain the required items to the customers, yet the information shall be in a form which is sufficiently brief not to confuse the customers or discourage the customers from completing the survey.

c. Whenever an EAS survey is conducted, the company shall mail to each customer account (primary service listing) a survey letter explaining the purpose of the survey, and a postage-paid, company-addressed return postcard on which the customer can indicate the customer's preference.

d. The company shall provide the board, for its approval, a copy of the proposed text and format of the customer letter and ballot survey card. The board may require alterations or corrections before permission is granted to proceed with the actual survey of the customers.

22.8(2) Procedures and requirements for establishing EAS studies.

a. The initiative for EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer shall include address and telephone number. Initiative for EAS may also come from the company or the board.

b. If the requirements of 22.8(2), paragraph "a," are fulfilled, a point-to-point usage study should be used to determine if sufficient community interest exists. There should be an average of five or more

calls per customer per month and more than 50 percent of the customers making at least two toll calls per month. If these basic criteria are not met, the request will be dismissed without further proceedings.

c. If the provisions of 22.8(2), paragraph "b," have been met, additional customer calling studies, cost and revenue studies including loss of toll revenues may be conducted, and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

d. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(3) Procedures and requirements for customer survey to establish EAS.

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

- (1) An explanation of the purpose of the survey.
- (2) A statement which identifies by class and grade of service the existing rate, the amount of rate increase and the new rate associated with the addition of the proposed EAS.
- (3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the proposal before further action will be taken.
- (4) A statement indicating the proposed date when service would be established which shall not be more than two years from the survey ballot return date, unless the delay is granted by the board due to the facility considerations.

(5) The date by which the ballot must be returned to be considered shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

- (1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.
- (2) A place for the customer to indicate whether customer favors or is opposed to the establishment of EAS.
- (3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years the ballots may be destroyed; however, the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers in an exchange vote in favor of EAS to another exchange but concurrence in two-way EAS is not received from that second exchange then consideration may be given to one-way EAS. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include information concerning lack of concurrence on two-way service by the neighboring exchange and that another survey is being taken to determine interest in one-way calling.

22.8(4) Procedures and requirements for discontinuing EAS.

a. The initiative to discontinue EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer must include address and telephone number. Initiative to discontinue EAS may also come from the company or the board.

b. Customer calling studies, cost and revenue studies may be conducted and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

c. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(5) Procedures and requirements for customer survey to discontinue EAS.

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

- (1) An explanation of the purpose of the survey.
- (2) A statement which identifies by class and grade of service the amount of rate decrease, if any, and the new rates associated with the proposed discontinuance of EAS.

(3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the discontinuance proposal before further action will be taken.

(4) A statement indicating the proposed date when service would be discontinued (which shall not be more than six months from the survey ballot return date).

(5) The date by which the ballots must be returned to be considered. This return date shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

(1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.

(2) A place for the customer to indicate whether customer favors or is opposed to the discontinuance of EAS.

(3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years, the ballot may be destroyed; provided, however, a record showing the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers approve discontinuance of two-way EAS to another exchange and concurrence in that discontinuance cannot be obtained from the customers of the second exchange, consideration may be given to continuance of one-way EAS by that second exchange. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include a statement indicating that the neighboring exchange or its customers have voted to discontinue two-way EAS and that this survey is being taken to determine interest in one-way calling.

199—22.9(476) Terminal equipment. Terminal equipment is deregulated. Customers may secure terminal equipment through any provider.

199—22.10(476) Unfair practices. All unfair or deceptive practices related to customer provision of equipment are prohibited. Any failure to provide information to customers or to deal with customers who provide their own terminal equipment or inside station wiring or an alteration of the charges for or availability of equipment or services on that ground, unless specifically authorized by board order or rule and by the utility's tariff, shall constitute unfair or deceptive practices. In cases of equipment in compliance with Federal Communications Commission registration requirements, telephone utility personnel are prohibited from making any statement, express or implied, to, or which will reach, a customer or prospective customer that terminal equipment in compliance with Federal Communications Commission registration requirements cannot properly be attached to the telephone network. This does not apply to good-faith efforts to amend the Federal Communications Commission requirements.

The listing of unfair practices in this rule shall not limit the types of acts which may be found to be unfair nor shall those listed be used to establish decisional criteria operating to exempt any act otherwise unfair from the intent of this rule.

199—22.11(476) Inside station wiring standards.

22.11(1) Construction by user limitation. A user shall not be allowed to construct inside station wiring from a demarcation point or between two or more buildings on the same premises to obtain service from an exchange other than that by which the user would normally be served, excluding users being provided adjacent exchange service or foreign exchange service as provided in a company's tariff. Existing inside wiring obtaining local exchange service within another exchange boundary shall be disconnected by the user within ten days after receipt of written notification from the local exchange company.

22.11(2) Standards applicable to inside station wiring. The following technical standards must be complied with:

- a. Applicable registration standards promulgated by the Federal Communications Commission.
- b. 47 CFR Part 68.
- c. Applicable national, state or local building and electrical codes, including National Electrical Code, as defined in 199—subrule 25.2(5); and accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and safety of persons and property.

199—22.12(476) Contents of tariff filings proposing rates.

22.12(1) Construction of rule. This rule shall be construed in a manner consistent with its purpose to expedite informed consideration of tariff filings proposing rates by ensuring the availability of relevant information on a standardized basis. Unless a waiver is granted prior to filing, this rule shall apply to all tariff filings by rate-regulated telephone utilities proposing rates, except the tariff filings of AOS utilities that propose rates at or below the corresponding rates for similar services of utilities whose rates have been approved by the board in a rate case or set in a market determined by the board to be competitive.

22.12(2) Cost studies to be filed. Rescinded IAB 6/3/09, effective 7/8/09.

22.12(3) Specification of cost methodologies. Rescinded IAB 6/3/09, effective 7/8/09.

22.12(4) Rescinded, effective June 10, 1987.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.13(476) Methodology for determining costs to serve. Rescinded IAB 6/3/09, effective 7/8/09.

199—22.14(476) Intrastate access charge application, tariff procedures, and rates.

22.14(1) Application of intrastate access charges.

a. Intrastate access charges shall apply to all intrastate access services rendered to interexchange utilities. Intrastate access charges shall not apply to EAS traffic. In the case of resale of services of interexchange utilities, access charges shall apply as follows:

- (1) The interexchange utilities shall be billed as if no resale were involved.
- (2) The resale carrier shall be billed only for access services not already billed to the underlying interexchange utility.

(3) Specific billing treatment and administration shall be provided pursuant to tariff.

b. Except as provided in 22.14(1)“b”(3), no person shall make any communication of the type and nature transmitted by telephone utilities, between exchanges located within Iowa, over any system or facilities, which are or can be connected by any means to the intrastate telephone network, and uses exchange utility facilities, unless the person shall pay to the exchange utility or utilities which provide service to the exchange where the communication is originated and the exchange where it is terminated, in lieu of the carrier common line charge, a charge in the amount of \$25 per month per circuit that is capable of interconnection. However, if the person provides actual access minutes to the exchange utility, the charge shall be the charge per access minute or fraction thereof provided in 22.14(2)“d”(1), not to exceed \$25 per line per month. The charge shall apply in all exchanges. However, if the person attests in writing that its facility cannot interconnect and is not interconnected with the exchange in question, the person will not be subject to the charge in that exchange.

(1) In the event that a communication is made without compliance with this rule, the telephone utility or utilities serving the person shall terminate telephone service after notice pursuant to subrule 22.4(5). The utility shall not reinstate service until the board orders the utility to restore service. The board shall order service to be restored when it has reasonable assurance that the person will comply with this rule.

(2) In any action concerning this rule, the burden of proof shall be upon the person making intrastate communications.

(3) This rule shall be inapplicable to:

1. Communications made by a person using facilities or services of telephone utilities to which an intrastate carrier common line charge applies pursuant to 22.14(3) "a."

2. Administrative communications made by or to a telephone utility.

22.14(2) Filing of intrastate access service tariffs.

a. Tariffs providing for intrastate access services shall be filed with the board by a telephone utility which provides such services. Iowa intrastate access service tariffs of rate-regulated utilities shall be based only on Iowa intrastate costs. Unless otherwise provided, the filings are subject to the applicable rules of the board.

b. A non-rate-regulated local exchange utility in its general tariff may concur in the intrastate access tariff filed by another non-rate-regulated local exchange utility.

(1) Alternatively, a non-rate-regulated local exchange utility may voluntarily elect to join another nonrate regulated local exchange utility or utilities in forming an association of local exchange utilities. The association may file intrastate access service tariffs. A utility in its general tariff can concur in the association tariffs.

(2) All elements of the filings, under rule 22.14(476) including access service rate elements, shall be subject to review and approval by the board.

c. Rescinded IAB 2/7/90, effective 3/14/90.

d. All intrastate access service tariffs shall incorporate the following:

(1) Carrier common line charge. The rate for the intrastate carrier common line charge shall be three cents per access minute or fraction thereof for both originating and terminating segments of the communication, unless a different rate is required by numbered paragraphs "1" and "2." The carrier common line charge shall be assessed to exchange access made by any interexchange telephone utility, including resale carriers. In lieu of this charge, interconnected private systems shall pay for access as provided in 22.14(1) "b."

1. Incumbent local exchange carrier intrastate access service tariffs shall include the carrier common line charges approved by the board.

2. A competitive local exchange carrier that concurs with the Iowa Telephone Association (ITA) Access Service Tariff No. 1 and that offers service in exchanges where the incumbent local exchange carrier's intrastate access rate is lower than the ITA access rate shall deduct the carrier common line charge from its intrastate access service tariff.

(2) End-user charge. No intrastate end-user charge shall be assessed.

(3) Universal service fund. No universal service fund shall be established.

(4) Transitional and premium rates. There shall be no discounted transitional rate elements applied in Iowa except as otherwise specifically set forth in these rules.

(5) Recording function of billing and collections. The intrastate access service tariffs shall include the rate to be charged for performing the recording function associated with billing and collections.

(6) A telephone utility may, pursuant to tariff, bill for access on the basis of assumed minutes of use where measurement is not practical. However, if the interexchange utility provides actual minutes of use to the billing utility, the actual minutes shall be used.

(7) In the absence of a waiver granted by the board, local exchange utilities shall allow any interexchange utility the option to use its own facilities that were in service on March 19, 1992, to provide local access transport service to terminate its own traffic to the local exchange utility. The interexchange utility may use its facilities in the manner and to a meet point agreed upon by the local exchange utility and the interexchange utility as of March 19, 1992. Changes mutually agreeable to the local exchange utility and the interexchange utility after that date also shall be recognized in allowing the interexchange utility to use its own local access transport facilities to terminate its own traffic. Recognition under this rule will also be extended to improvements by an interexchange utility that provided all the transport facilities to an exchange on March 19, 1992, whether the improvements were mutually agreeable or not, unless the improvements are inconsistent with an agreement between the interexchange utility and the local exchange utility.

22.14(3) Rescinded, IAB 9/21/88, effective 10/26/88.

22.14(4) Notice of intrastate access service tariffs.

a. Each telephone utility that files new or changed tariffs relating to access charges, access service, or the recording function associated with billing and collection for access services shall give written notice of the new or changed tariffs to the utility's interexchange utility access customers, the board, and the consumer advocate. Notice shall be given on or before the date of filing of the tariff. The notice shall consist of: the file date, the proposed effective date, a description of the proposed changes, and the tariff section number where the service description is located. If two or more local exchange utilities concur in a single tariff filing, the local exchange utilities may send a joint written notice to the board, consumer advocate, and the interexchange utilities.

b. The board shall not approve any new or changed tariff described in paragraph "a" until after the period for resistance provided in subrule 22.14(5), paragraph "a."

22.14(5) Resistance to intrastate access service tariffs.

a. If an interexchange utility affected by an access service filing or the consumer advocate desires to file a resistance to a proposed new or changed access service tariff, it shall file its resistance within 14 days after the filing of the proposed tariff. The interexchange utility shall send a copy of the resistance to all telephone utilities filing or concurring in the proposed tariff.

b. After receipt of a timely resistance, the board may:

(1) Deny the resistance if it does not on its face present a material issue of adjudicative fact or the board determines the resistance to be frivolous or otherwise without merit and allows the tariff to go into effect by order or by operation of law; or

(2) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate informal complaint proceedings; or

(3) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate contested case proceedings; or

(4) Reject the tariff, stating the grounds for rejection.

c. The interexchange utility or the consumer advocate shall have the burden to support its resistance.

d. If contested case proceedings are initiated upon resistance filed by an interexchange utility, the interexchange utility shall pay the expenses reasonably attributable to the proceeding unless the interexchange utility is the successful party as determined by the board.

22.14(6) Access charge rules to prevail. The provisions of rule 22.14(476) shall be determinative of the procedures relating to intrastate access service tariffs and shall prevail over all inconsistent rules. [ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.15(476) Interexchange utility service and access.

22.15(1) Interexchange utility service. An interexchange utility may provide interexchange service by complying with the laws of this state and the rules of this board. Any company or other entity accessing local exchange facilities or services in order to provide interexchange communication services to the public shall be considered to be an interexchange utility and subject to the rules herein, unless otherwise exempted. Such utilities are required to file a registration form, reports, and other items and are subject to service standards as specified in utilities division rules, unless otherwise exempted.

22.15(2) Interexchange utility intrastate access. Intrastate access to local exchange services or facilities may be obtained by an interexchange utility by ordering and paying for such intrastate access pursuant to the applicable tariff filed by the exchange utility in question, or as otherwise provided by agreement between the parties.

22.15(3) Willful violation. Any interexchange utility which the board finds has willfully failed to pay the intrastate carrier common line charge as specified in 22.14(3) "a" shall be in willful violation of board rules.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.16(476) Discontinuance of service. No local exchange utility or interexchange utility may discontinue providing intrastate service to any local exchange or part of a local exchange except in the

case of emergency, nonpayment of account, or violation of rules and regulations; except as provided below.

22.16(1) Prior to discontinuing service, the utility shall file with the board and consumer advocate a notice of intent to discontinue service at least 90 days prior to the proposed date of discontinuance. However, if the utility shows it has no customers for the service it proposes to discontinue, the utility need only file such notice 30 days prior to discontinuance.

22.16(2) The notice of discontinuance of service shall include the following:

1. The name and address of the utility involved;
2. The name, title, and address of the person to whom correspondence concerning the notice should be directed;
3. A description of the nature of and reasons for the proposed discontinuance;
4. Identification of the exchange or part of exchange involved and the date on which the utility desires to discontinue service;
5. A description of the area affected and an assessment of the impact on present and future public convenience and necessity of such discontinuance, including the name and address of any other utility currently or potentially providing the same or substitute service to the area;
6. A description of the service proposed to be discontinued, of the existing service available to the exchange or part of exchange involved, and of the service of the applying utility or others which would remain in the event approval is granted.

22.16(3) If after 30 days of the filing of such notice, no action is taken by the board, the discontinuance may take place as proposed.

22.16(4) The board, on its own motion or at the request of the consumer advocate or affected customer, may hold a hearing on such discontinuance.

199—22.17(476) Resale of service.

22.17(1) Any landlord, owner, tenant association, or otherwise affiliated group shall be permitted to provide communications services within or between one or more buildings with a community of interest. The provision of this service will be treated as a deregulated service, if the following requirements are met:

- a. No person within a building or facility providing resale services shall be denied access to the local exchange carrier. The local exchange carrier shall provide service at normal tariffed rates to the point of demarcation. The end-user shall be responsible for service beyond that point. However, no person shall unreasonably inhibit the end-user's access to the local exchange carrier.
- b. Telephone rates charged to resale providers of communications services under this rule shall be made on the same basis as business service.
- c. "Community of interest" will normally be indicated by joint or common ownership, but any other relevant factors may be considered.

22.17(2) Any interested person may request formal complaint proceedings with respect to any existing or proposed resale arrangement under this rule. Complaints may concern, but are not limited to:

- a. Whether the reseller is, in fact, a local exchange carrier in its own right, as demonstrated by limitations on access to the original local exchange carrier, the geographical area of the offering, or other relevant factors; and
- b. Whether the reseller is allowing access to the local exchange carrier on reasonable terms.

199—22.18(476) Low-income connection assistance program. Rescinded IAB 12/31/97, effective 1/1/98.

199—22.19(476) Alternative operator services.

22.19(1) Definitions. The definitions found in Iowa Code section 476.91 apply to this rule.

22.19(2) Tariffs. Alternative operator service companies must provide service pursuant to board-approved tariffs covering both rates and service.

22.19(3) Blocking. AOS companies shall not block the completion of calls which would allow the caller to reach a long distance telephone company different from the AOS company. All AOS company contracts with contracting entities must prohibit call blocking by the contracting entity. The contracting entity shall not violate that contract provision.

22.19(4) Posting. Contracting entities must post on or in close proximity to all telephones served by an AOS company the following information:

- a. The name and address of the AOS company;
- b. A customer service number for receipt of further service and billing information; and
- c. Dialing directions to the AOS operator for specific rate information.

Contracts between AOS companies and contracting entities shall contain provisions for posting the information. The AOS companies also are responsible for the form of the posting and shall make reasonable efforts to ensure implementation, both initially and on an updated basis.

22.19(5) Oral identification. All AOS companies shall announce to the end-user customer the name of the provider carrying the call and shall include a sufficient delay period to permit the caller to terminate the call or advise the operator to transfer the call to the end-user customer's preferred carrier before billing begins.

22.19(6) Billing. All AOS company bills to end-user customers shall comply with the following requirements, in addition to the requirements of subrule 22.4(3):

- a. All calls, except those billed to commercial credit cards, shall be itemized and identified separately on the bill. All calls will be rated solely from the end-user customer's point of origin to point of termination.
- b. All bills, except those for calls billed to commercial credit cards, shall be rendered within 60 days of the provision of the service.
- c. All charges for the use of a telephone instrument shall be shown separately for each call, except for calls billed to a commercial credit card.

22.19(7) Emergency calls. All AOS companies shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

199—22.20(476) Service territories. Service territories are defined by the telephone exchange area boundary maps on file with the Iowa utilities board. The maps will be available for viewing at the board's office during regular business hours and copies are available at the cost of reproduction. This rule does not apply to resale of local telephone service pursuant to rule 22.17(476).

22.20(1) Issuance of certificates of authority to utilities on or prior to September 30, 1992. The initial nonexclusive certificate of authority will be issued by the board on or before September 30, 1992, to each land-line telephone utility providing local telecommunications service in Iowa. The certificate will authorize service within the territory as shown by boundary maps in effect on January 1, 1992, but will reference and include modifications approved by the board prior to the issuance of the certificate. The certificate will be in the form of an order issued by the board and may be modified only by subsequent board orders.

If a utility disputes the boundary identified in the January 1, 1992, maps or in a certificate, it may file an objection with the board. After notice to interested persons and an opportunity for hearing, the board will determine the boundary.

22.20(2) Procedures to revise maps and modify certificates. All territory in the state shall be served by a local exchange utility and inappropriate overlaps of service territories are to be avoided.

a. When the board, after informal investigation, determines a significant gap or overlap exists on the maps on file defining service territories, affected utilities and interested persons, including affected customers, will be notified. The board will direct the affected utilities to file a proposed boundary within 30 days, if the utilities can agree.

b. The boundary filing must include the name of each affected customer and justification for the proposed boundary, including a detailed statement of why the proposal is in the public interest. Prior to filing with the board, the serving utilities must notify interested persons of a convenient location where

they can view the current and proposed maps, or copies of the maps covering their location must be mailed to them. The notice shall state the nature of the boundary filing and that any objections must be mailed to the board postmarked within 14 days of the mailing of the notice by the utility. The utility's filing shall also include a copy of the notice and the date on which the notice was mailed to customers.

c. Upon board approval of the proposed boundary, the affected utilities shall file revised maps which comply with subrule 22.20(3) and, upon approval of the maps, the board will modify the certificates.

d. If the utilities cannot agree on the boundary, or if an interested person timely mails material objections to the proposed boundary, the board will resolve the issues in contested case proceedings to revise the maps and modify the certificates after notice of the proceedings to all affected utilities and interested persons.

e. A voluntary modification petition filed jointly by all affected utilities pursuant to 1992 Iowa Acts, Senate File 511, shall contain the information required in 22.20(2) "b." The notice and hearing requirements in 22.20(2) "b" through "d" shall be observed in voluntary modification proceedings.

f. A post-January 1, 1992, map will not be effective in defining a utility's service territory until approved by the board.

22.20(3) Map specifications. All ILECs shall have on file with the board maps which identify their exchanges and both internal exchange boundaries where the utility's own exchanges abut and ultimate boundaries where the utility's exchanges abut other utilities. A CLEC shall either file its own exchange boundary map or adopt the exchange boundary map filed by the ILEC serving that exchange.

a. Each utility's maps shall be on a scale of one inch to the mile. They shall include information equivalent to the county maps which are available from the Iowa department of transportation, showing all roads, railroads, waterways, plus township and range lines outside the municipalities. A larger scale shall be used where necessary to clarify areas. All map details shall be clean-cut and readable.

(1) Each filed map shall clearly show the ultimate utility boundary line; this line shall be periodically marked with the letter "U." Exchange boundaries where the utility's own exchanges abut shall be periodically marked with the letter "E." Ultimate and exchange boundary lines shall be drawn on a section, half-section, or quarter-section line. If not, the distance from a section line or other fixed reference point shall be clearly noted. When using a fixed reference point, measurement shall always be from the center of the fixed point.

(2) The map shall also identify the utility serving each contiguous exchange. The utility names shall be placed about the exterior of the ultimate boundary. The points at which the adjacent exchange meets the ultimate boundary will be marked with arrows.

(3) Plant facilities shall not be shown on the boundary map. Approximate service locations may be shown but are not required.

(4) The name of the utility filing the map shall be placed in the upper right corner of the map. This will be followed by the names of each exchange shown on the map and served by that utility. The last item will be the date the map is filed and the proposed effective date, which will be 30 days after the filing date unless the board sets a different date.

b. If requested by the board, a legal description shall be filed to clarify an ambiguous boundary between utilities. The legal description shall conform with the standards set in Iowa Code section 114A.9.

22.20(4) Subsequent certificates. Any legal entity which desires to serve all or a portion of a territory which is currently assigned to another land-line utility may petition for a new certificate or a certificate modification depending upon whether the utility already has a certificate to serve. After notice to affected utilities and opportunity for hearing, the board will determine whether the new certificate or certificate modification will promote the public convenience and necessity. If the new or modified certificate is granted, the result may be two or more utilities serving all or a portion of an assigned territory.

22.20(5) Certificate revocation. Any five subscribers or potential subscribers, or consumer advocate upon filing a sworn statement showing a generalized pattern of inadequate telephone service or facilities may petition the board to begin formal certificate revocation proceedings against a local exchange utility. While similar in nature to a complaint filed under rule 199—6.2(476), a petition under this rule shall be addressed by the board under the following procedure and not the procedure found in 199—Chapter 6.

a. Upon receiving a petition, the board will make an informal preliminary investigation into the adequacy of the service and facilities provided by a local exchange utility. The board also may begin an informal preliminary investigation on its own motion at any time.

b. Prior to beginning formal revocation proceedings under 1992 Iowa Acts, Senate File 511, the board will provide notice to the utility of any alleged inadequacies in its service. The utility may admit or deny the allegations. If admitted, the utility will have a reasonable time to eliminate the inadequacies. If denied, the utility will have the opportunity to refute the allegations in contested case proceedings after mailed notice and an opportunity to intervene for the utility's affected customers.

c. If the board does not issue the notice of alleged inadequacies to the utility as provided in 22.20(2) "b" within 60 days after the filing of the petition, the petition will be deemed denied.

d. If the board finds significant inadequacies in service or facilities in any certificate revocation contested case, the utility will be allowed a reasonable time to eliminate the inadequacies.

e. If the utility fails to eliminate significant inadequacies in service or facilities within a reasonable time, the board, after mailed notice to all parties in the contested case, or to affected customers if the utility admitted the inadequacies, and after an opportunity for hearing, may revoke or condition the certificate as provided in 1992 Iowa Acts, Senate File 511.

f. Proceedings under this subrule may be combined with proceedings under subrule 22.20(4), or similar certification proceedings initiated on the board's own motion, to consider an appropriate replacement utility simultaneously with the revocation case.

[ARC 7826B, IAB 6/3/09, effective 7/8/09]

199—22.21(476) Toll dialing patterns. All local exchange utilities shall use the dialing pattern, 0 or 1 plus ten digits, for all toll calls either within a single numbering plan area or from one numbering plan area to another.

199—22.22(476) Requests for interconnection negotiations. Rescinded IAB 8/28/96, effective 8/2/96.

199—22.23(476) Unauthorized changes in telephone service.

22.23(1) Definitions. As used in this rule, unless the context otherwise requires:

"*Change in service*" means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, and includes the addition or deletion of a telecommunications service for which a separate charge is made to a customer account.

"*Consumer*" means a person other than a service provider who uses a telecommunications service.

"*Cramming*" means the addition or deletion of a product or service for which a separate charge is made to a telecommunication customer's account without the verified consent of the affected customer. Cramming does not include the addition of extended area service to a customer account pursuant to board rules, even if an additional charge is made. Cramming does not include telecommunications services that are initiated or requested by the customer, including dial-around services such as "10-10-XXX," directory assistance, operator-assisted calls, acceptance of collect calls, and other casual calling by the customer.

"*Customer*" means the person other than a service provider whose name appears on the account and others authorized by that named person to make changes to the account.

"*Executing service provider*" means, with respect to any change in telecommunications service, a service provider who executes an order for a change in service received from another service provider or from its own customer.

"*Jamming*" means the addition of a preferred carrier freeze to a customer's account without the verified consent of the customer.

"*Letter of agency*" means a written document complying with the requirements of 199 IAC 22.23(2) "b."

"*Preferred carrier freeze*" means the limitation of a customer's preferred carrier choices so as to prevent any change in preferred service provider for one or more services unless the customer gives the service provider from which the freeze was requested the customer's express consent.

“*Service provider*” means a person providing a telecommunications service, not including commercial mobile radio service.

“*Slamming*” means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, without the verified consent of the customer. “Slamming” does not include the designation of a new provider of a telecommunications service to a customer made pursuant to the sale or transfer of another carrier’s customer base, provided that the designation meets the requirements of 199 IAC 22.23(2) “e.”

“*Soft slam*” means an unauthorized change in service by a service provider that uses the carrier identification code (CIC) of another service provider, typically through the purchase of wholesale services for resale.

“*Submitting service provider*” means a service provider who requests another service provider to execute a change in service.

“*Telecommunications service*” means a local exchange or long distance telephone service other than commercial mobile radio service.

“*Verified consent*” means verification of a customer’s authorization for a change in service.

22.23(2) Prohibition of unauthorized changes in telecommunications service. Unauthorized changes in telecommunications service, including but not limited to cramming and slamming, are prohibited.

a. Verification required. No service provider shall submit a preferred carrier change order or other change in service order to another service provider unless and until the change has first been confirmed in accordance with one of the following procedures:

(1) The service provider has obtained the customer’s written authorization in a form that meets the requirements of 199 IAC 22.23(2) “b”; or

(2) The service provider has obtained the customer’s electronic authorization to submit the preferred carrier change order. Such authorization must be placed from the telephone number(s) on which the preferred carrier is to be changed and must confirm the information required in subparagraph (1) above. Service providers electing to confirm sales electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred carrier change, including automatically recording the originating automatic numbering identification; or

(3) An appropriately qualified independent third party has obtained the customer’s oral authorization to submit the preferred carrier change order that confirms and includes appropriate verification data. The independent third party must not be owned, managed, controlled, or directed by the service provider or the service provider’s marketing agent; must not have any financial incentive to confirm preferred carrier change orders for the service provider or the service provider’s marketing agent; and must operate in a location physically separate from the service provider or the service provider’s marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred carrier change; or

(4) The local service provider may change the preferred service provider, for customer-originated changes to existing accounts only, through maintenance of sufficient internal records to establish a valid customer request for the change in service. At a minimum, any such internal records must include the date and time of the customer’s request and adequate verification of the identification of the person requesting the change in service. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer’s request for the change in service.

All verifications shall be maintained for at least two years from the date the change in service is implemented. Verification of service freezes shall be maintained for as long as the preferred carrier freeze is in effect.

(5) For other changes in service resulting in additional charges to existing accounts only, a service provider shall establish a valid customer request for the change in service through maintenance of sufficient internal records. At a minimum, any such internal records must include the date and time of the customer’s request and adequate verification under the circumstances of the identification of the person requesting the change in service. Any of the three verification methods in 22.23(2) “a”(1) to (3)

will also be acceptable. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer's request for the change in service. Where the additional charge is for one or more specific telephone calls, examples of internal records a carrier may submit include call records showing the origin, date, time, destination, and duration of the calls, and any other data the carrier relies on to show the calls were made or accepted by the customer, along with an explanation of the records and data.

b. Letter of agency form and content.

(1) A service provider may use a letter of agency to obtain written authorization or verification of a customer's request to change the customer's preferred service provider selection. A letter of agency that does not conform with this subrule is invalid for purposes of this rule.

(2) The letter of agency shall be a separate document (or an easily separable document) containing only the authorizing language described in subparagraph (5) below having the sole purpose of authorizing a service provider to initiate a preferred service provider change. The letter of agency must be signed and dated by the customer to the telephone line(s) requesting the preferred service provider change.

(3) The letter of agency shall not be combined on the same document with inducements of any kind.

(4) Notwithstanding subparagraphs (2) and (3) above, the letter of agency may be combined with checks that contain only the required letter of agency language as prescribed in subparagraph (5) below and the necessary information to make the check a negotiable instrument. The letter of agency check shall not contain any promotional language or material. The letter of agency check shall contain, in easily readable, boldface type on the front of the check, a notice that the customer is authorizing a preferred service provider change by signing the check. The letter of agency language shall be placed near the signature line on the back of the check.

(5) At a minimum, the letter of agency must be printed with a type of sufficient size and readable type to be clearly legible and must contain clear and unambiguous language that confirms:

1. The customer's billing name and address and each telephone number to be covered by the preferred service provider change order;

2. The decision to change the preferred service provider from the current service provider to the soliciting service provider;

3. That the customer designates [insert the name of the submitting service provider] to act as the customer's agent for the preferred service provider change;

4. That the customer understands that only one service provider may be designated as the customer's interstate or interLATA preferred interexchange service provider for any one telephone number. To the extent that a jurisdiction allows the selection of additional preferred service providers (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, or international interexchange), the letter of agency must contain separate statements regarding those choices, although a separate letter of agency for each choice is not necessary; and

5. That the customer understands that any preferred service provider selection the customer chooses may involve a charge to the customer for changing the customer's preferred service provider.

(6) Any service provider designated in a letter of agency as a preferred service provider must be the service provider directly setting the rates for the customer.

(7) Letters of agency shall not suggest or require that a customer take some action in order to retain the customer's current service provider.

(8) If any portion of a letter of agency is translated into another language, then all portions of the letter of agency must be translated into that language. Every letter of agency must be translated into the same language as any promotional materials, oral descriptions or instructions provided with the letter of agency.

c. Customer notification. Every change in service shall be followed by a written notification to the affected customer to inform the customer of the change. Such notice shall be provided within 30 days of the effective date of the change. Such notice may include, but is not limited to, a conspicuous written statement on the customer's bill, a separate mailing to the customer's billing address, or a separate written statement included with the customer's bill. Each such statement shall clearly and conspicuously identify

the change in service, any associated charges or fees, the name of the service provider associated with the change, and a toll-free number by which the customer may inquire about or dispute any provision in the statement.

d. Preferred carrier freezes.

(1) A preferred service provider freeze (or freeze) prevents a change in a customer's preferred service provider selection unless the customer gives the service provider from whom the freeze was requested express consent. All local exchange service providers who offer preferred service provider freezes must comply with the provisions of this subrule.

(2) All local exchange service providers who offer preferred service provider freezes shall offer freezes on a nondiscriminatory basis to all customers, regardless of the customer's service provider selections.

(3) Preferred service provider freeze procedures, including any solicitation, must clearly distinguish among telecommunications services (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, and international toll) subject to a preferred service provider freeze. The service provider offering the freeze must obtain separate authorization for each service for which a preferred service provider freeze is requested.

(4) Solicitation and imposition of preferred service provider freezes.

1. All solicitation and other materials provided by a service provider regarding preferred service provider freezes must include:

- An explanation, in clear and neutral language, of what a preferred service provider freeze is and what services may be subject to a freeze;

- A description of the specific procedures necessary to lift a preferred service provider freeze; an explanation that these steps are in addition to the verification requirements in 22.23(2)“a” and 22.23(2)“b” for changing a customer's preferred service provider selections; and an explanation that the customer will be unable to make a change in service provider selection unless the freeze is lifted; and

- An explanation of any charges associated with the preferred carrier freeze.

2. No local exchange carrier shall implement a preferred service provider freeze unless the customer's request to impose a freeze has first been confirmed in accordance with one of the following procedures:

- The local exchange carrier has obtained the customer's written and signed authorization in a form that meets the requirements of 22.23(2)“d”(4)“3”; or

- The local exchange carrier has obtained the customer's electronic authorization, placed from the telephone number(s) on which the preferred service provider freeze is to be imposed, to impose a preferred service provider freeze. The electronic authorization shall confirm appropriate verification data and the information required in 22.23(2)“d”(4)“3.” Service providers electing to confirm preferred service provider freeze orders electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred service provider freeze request, including automatically recording the originating automatic numbering identification; or

- An appropriately qualified independent third party has obtained the customer's oral authorization to submit the preferred service provider freeze and confirmed the appropriate verification data and the information required in 22.23(2)“d”(4)“3.” The independent third party must not be owned, managed, or directly controlled by the service provider or the service provider's marketing agent; must not have any financial incentive to confirm preferred service provider freeze requests for the service provider or the service provider's marketing agent; and must operate in a location physically separate from the service provider or the service provider's marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred service provider freeze.

3. A local exchange service provider may accept a written and signed authorization to impose a freeze on the customer's preferred service provider selection. Written authorization that does not conform with this subrule is invalid and may not be used to impose a preferred service provider freeze.

- The written authorization shall comply with 22.23(2) “b”(5)“2” and “3” and 22.23(2) “b”(8) concerning the form and content for letters of agency.

- At a minimum, the written authorization must be printed with a readable type of sufficient size to be clearly legible and must contain clear and unambiguous language that confirms: (1) the customer’s billing name and address and the telephone number(s) to be covered by the preferred service provider freeze; (2) the decision to place a preferred service provider freeze on the telephone number(s) and particular service(s). To the extent that a jurisdiction allows the imposition of preferred service provider freezes on additional preferred service provider selections (e.g., for local exchange, intraLATA/intrastate toll, interLATA/interstate toll service, and international toll), the authorization must contain separate statements regarding the particular selections to be frozen; (3) that the customer understands that the customer will be unable to make a change in service provider selection unless the preferred service provider freeze is lifted; and (4) that the customer understands that any preferred carrier freeze may involve a charge to the customer.

(5) All local exchange service providers who offer preferred service provider freezes must, at a minimum, offer customers the following procedures for lifting a preferred service provider freeze:

1. A local exchange service provider administering a preferred service provider freeze must accept a customer’s written and signed authorization stating the intention to lift a preferred service provider freeze; and

2. A local exchange service provider administering a preferred service provider freeze must accept a customer’s oral authorization stating the intention to lift a preferred carrier freeze and must offer a mechanism that allows a submitting service provider to conduct a three-way conference call with the service provider administering the freeze and the customer in order to lift a freeze. When engaged in oral authorization to lift a preferred service provider freeze, the service provider administering the freeze shall confirm appropriate verification data and the customer’s intent to lift the particular freeze.

e. Procedures in the event of sale or transfer of customer base. A telecommunications carrier may acquire, through a sale or transfer, either part or all of another telecommunications carrier’s customer base without obtaining each customer’s authorization in accordance with 199 IAC 22.23(2) “a,” provided that the acquiring carrier complies with the following procedures. A telecommunications carrier may not use these procedures for any fraudulent purpose, including any attempt to avoid liability for violations under 199 IAC 22.23(2) “a.”

- (1) No later than 30 days before the planned transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall file with the board a letter notifying the board of the transfer and providing the names of the parties to the transaction, the types of telecommunications services to be provided to the affected customers, and the date of the transfer of the customer base to the acquiring carrier. In the letter, the acquiring carrier also shall certify compliance with the requirement to provide advance customer notice in accordance with 199 IAC 22.23(2) “e”(3) and with the obligations specified in that notice. In addition, the acquiring carrier shall attach a copy of the notice sent to the affected customers.

- (2) If, subsequent to the filing of the letter of notification with the board required by 199 IAC 22.23(2) “e”(1), any material changes to the required information develop, the acquiring carrier shall file written notification of these changes with the board no more than 10 days after the transfer date announced in the prior notification. The board may require the acquiring carrier to send an additional notice to the affected customers regarding such material changes.

- (3) Not later than 30 days before the transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall provide written notice to each affected customer. The acquiring carrier must fulfill the obligations set forth in the written notice. The written notice must inform the customer of the following:

1. The date on which the acquiring carrier will become the customer’s new provider of telecommunications service;

2. The rates, terms, and conditions of the service(s) to be provided by the acquiring carrier upon the customer’s transfer to the acquiring carrier, and the means by which the acquiring carrier will notify the customer of any change(s) to these rates, terms, and conditions;

3. The acquiring carrier will be responsible for any carrier change charges associated with the transfer;

4. The customer’s right to select a different preferred carrier for the telecommunications service(s) at issue, if an alternative carrier is available;

5. All customers receiving the notice, even those who have arranged preferred carrier freezes through their local service providers on the service(s) involved in the transfer, will be transferred to the acquiring carrier unless they have selected a different carrier before the transfer date; existing preferred carrier freezes on the service(s) involved in the transfer will be lifted; and the customers must contact their local service providers to arrange a new freeze;

6. Whether the acquiring carrier will be responsible for handling any complaints filed, or otherwise raised, prior to or during the transfer against the selling or transferring carrier; and

7. The toll-free customer service telephone number of the acquiring carrier.

22.23(3) Carrier registration.

a. *Registration required.* Each carrier that provides or bills for telecommunications services to customers located in Iowa shall register with the board and shall provide, at a minimum, the information specified in the form that appears in this subrule.

DEPARTMENT OF COMMERCE
UTILITIES BOARD

TELECOMMUNICATIONS SERVICE PROVIDER REGISTRATION

1. FULL NAME OF CARRIER PROVIDING SERVICE IN IOWA:

2. CARRIER MAILING ADDRESS (including 9-digit ZIP code):

3. NAME, TITLE, TELEPHONE NUMBER, E-MAIL ADDRESS, AND FAX NUMBER OF CONTACT PERSON:

4. ALL TRADE NAMES OR D/B/A’S USED BY CARRIER IN IOWA OR IN ADVERTISING OR BILLING THAT MAY REACH IOWA CUSTOMERS:

5. NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF AGENT IN IOWA AUTHORIZED TO ACCEPT SERVICE OF PROCESS ON BEHALF OF CARRIER:

6. TYPES OF TELECOMMUNICATIONS SERVICE PROVIDED (CHECK ALL THAT APPLY):

- LOCAL EXCHANGE SERVICE
- INTEREXCHANGE SERVICE
- DATA TRANSMISSION
- ALTERNATIVE OPERATOR SERVICES ONLY
- OTHER—PLEASE SPECIFY: _____

7. ATTESTATION. I, _____, certify that I am the company officer responsible for this registration, that I have examined the foregoing registration, and that to the best of my knowledge, information, and belief the information is accurate and will be updated as required.

Dated ____/____/____

SIGNATURE _____

b. Failure to register. Failure to file and reasonably update a registration, or provision of false, misleading, or incomplete information, may result in civil penalties under 22.23(5) and may be considered as evidence of a pattern or practice of violation of these rules.

22.23(4) Subscriber complaints regarding changes in service—procedures. When a telecommunications service provider is contacted by an Iowa customer alleging an unauthorized change in service, the service provider shall inform the customer of the customer's right to contact the board regarding the complaint. The service provider shall provide the customer with the board's toll-free number for complaints, (877)565-4450.

When a subscriber submits to the board a written complaint alleging an unauthorized change in service, the complaint will be processed by the board pursuant to 199—Chapter 6, "Complaint Procedures."

22.23(5) Civil penalties and assessment of damages.

a. Civil penalties. In addition to any applicable civil penalty set out in Iowa Code section 476.51, a service provider who violates a provision of the anti-slamming statute, a rule adopted pursuant to the anti-slamming statute, or an order lawfully issued by the board pursuant to the anti-slamming statute is subject to a civil penalty, which, after notice and opportunity for hearing, may be levied by the board, of not more than \$10,000 per violation. Each violation is a separate offense.

b. Amount. A civil penalty may be compromised by the board. In determining the amount of the penalty, or the amount agreed upon in a compromise, the board may consider the size of the service provider, the gravity of the violation, any history of prior violations by the service provider, remedial actions taken by the service provider, the nature of the conduct of the service provider, and any other relevant factors.

c. Collection. A civil penalty collected pursuant to this subrule shall be forwarded by the executive secretary of the board to the treasurer of state to be credited to the general fund of the state and to be used only for consumer education programs administered by the board.

d. Exclusion from regulated rates. A penalty paid by a rate-of-return regulated utility pursuant to this subrule shall be excluded from the utility's costs when determining the utility's revenue requirement and shall not be included either directly or indirectly in the utility's rates or charges to its customers.

e. Civil actions. The board shall not commence an administrative proceeding to impose a civil penalty under this rule for acts subject to a civil enforcement action pending in court under Iowa Code section 714D.7.

f. Assessment of damages among interested persons. As a part of formal complaint proceedings, the board may determine the potential liability, including assessment of damages, for unauthorized changes in service among the customer, the previous service provider, the executing service provider, the submitting service provider, and any other interested persons. In the event of a soft slam, the board may impose joint and several liability on the reseller and the facilities-based service provider. For purposes of this rule and in the absence of unusual circumstances, the term "damages" means charges directly relating to the telecommunications services provided to the customer that have appeared or may appear on the customer's bill. The term "damages" does not include incidental, consequential, or punitive damages.

22.23(6) Penalties for patterns of violations. If the board determines, after notice and opportunity for hearing, that a service provider has shown a pattern of violations of these rules, the board may by order do any of the following:

a. Prohibit any other service provider from billing charges to residents of Iowa on behalf of the service provider determined to have engaged in such a pattern of violations.

b. Prohibit certificated local exchange service providers from providing exchange access services to the service provider.

c. Limit the billing or access services prohibition under paragraph "a" or "b" above to a period of time. Such prohibition may be withdrawn upon a showing of good cause.

d. Revoke the certificate of public convenience and necessity of a local exchange service provider.

22.23(7) Service provider complaints regarding changes in service. When a service provider files a written complaint charging another service provider with causing unauthorized changes in end user

services to the detriment of the complaining service provider, the complaint will be processed pursuant to 199—Chapter 6, “Complaint Procedures,” except that any party to the proceeding may petition the board for an order initiating formal complaint proceedings at any time, regardless of the status of the informal complaint proceedings. The board will grant such petitions or enter such an order on its own motion if the board finds that informal complaint proceedings are unlikely to aid in the resolution of the complaint.

199—22.24(476) Applications for numbering resources.

22.24(1) *Application to be filed with the board.* Any communications service provider, including but not limited to local exchange carriers, wireless service providers, and paging companies, applying for numbering resources with the North American Numbering Plan Administrator (NANPA) or the Pooling Administrator (PA) shall send a draft application or executed application to the board by facsimile transfer or electronic mail at least two days prior to the date on which the original application is to be received by the NANPA or PA. A draft application shall contain substantially the same information that is to be contained in an executed application. The application may be faxed to (515)281-5329 or electronically mailed to iubrecordscenter@iub.state.ia.us. Electronic submissions shall include “NANPA Application” or “PA Application” in the subject line.

22.24(2) *Confidential treatment.* The information contained in the draft applications or executed applications for numbering resources shall be held as confidential for a period of 90 days or until the new codes are entered into the local exchange routing guide (LERG), whichever is later.

22.24(3) *Content.* Each application filed with the board under this rule shall include a reference to this rule and sufficient information to identify the service provider and a contact person.

These rules are intended to implement Iowa Code sections 476.1 to 476.3, 476.5, 476.6, 476.8, 476.9, 476.29, 476.91, and 546.7 and Iowa Code Supplement section 476.103.

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CHAPTER 1
COMMUNITY EMPOWERMENT

349—1.1(28) Scope. Community empowerment is created to establish partnerships between state government and communities. The emphasis is to develop community empowerment areas to improve the well-being of children and their families and, through collaboration, to improve the efficiency and effectiveness of local early care, education, health and human services.

349—1.2(28) Purpose. Community empowerment is intended to empower individuals and their communities to achieve desired results to improve the quality of life for children and their families in Iowa. Community empowerment will enable local citizens to lead collaborative efforts involving early care, education, health, and human services on behalf of children, families, and other citizens residing in the area. It is believed that individuals in local communities working together through the process of community assessment, identification of priorities and development of their community plan is the best means to reach desired results. The role of the Iowa empowerment board and the state is to support and facilitate growth of individual and community responsibility in place of the directive role the public has come to expect of government.

Every community in Iowa will develop the capacity and commitment to achieve these desired results for children and their families:

1. Healthy children.
2. Children ready to succeed in school.
3. Safe and supportive communities.
4. Secure and nurturing families.
5. Secure and nurturing early care and education environments.

349—1.3(28) Availability. Community empowerment areas are statewide to promote collaboration among state and local education, health, and human services, consumers, business, faith organizations and public and private organizations to reach the desired results.

349—1.4(28) Definitions. For the purpose of these rules, the following definitions apply:

“Accountable” means the community board will include the public in assessing, setting priorities, and developing and implementing a community plan to reach the purpose and desired results of empowerment and will ensure that adequate records are maintained.

“Advocacy” means to promote the purpose of community empowerment, promote the enhancement and expansion of the community plan and promote individual and family access to formal and informal support.

“Alignment” means state- and community-level interagency efforts to integrate early care, health, and education systems and enhance state and community partnerships through innovative approaches.

“Business community investment advisory council” means a council created by the Iowa legislature to provide recommendations on building a public-private partnership for early childhood in Iowa.

“Central office of empowerment” means a facilitator (appointed by the governor) and staff in the Iowa department of management.

“Citizen representative” means a resident of the empowerment area, who is not an elected official or a required representative for education, health, and human services, or a paid staff member of an agency whose services fall under the plan or purview of the community board. A citizen representative may also represent faith, consumer or business.

“Community assessment” means to identify all formal and informal supports, assets and resources, as well as gaps, in the empowerment area for children and their families. A community assessment includes communitywide data, statistics, and facts upon which to base decisions to develop a community plan and to identify priorities to reach the desired results.

“Community board” means the governing board for an empowerment area.

“Community board advisory council” means individuals appointed by the community board to function on a continuing basis to study and recommend policy and guidelines for the empowerment area.

“Community plan” means the local school ready grant plan, adopted by the community board following input from the community, implemented in the empowerment area.

“Consumer” means an individual or a family member who is or has been receiving services or who is impacted by the community plan.

“Culturally competent” means the capacity to function across cultures, requiring the ability to appreciate, understand and interact with members of diverse populations within the community.

“Decategorization project” means the human services decategorization of child welfare and juvenile justice funding project operated under Iowa Code section 232.188.

“Designation” means the status awarded by the Iowa board to an empowerment area meeting the criteria for geographic boundaries, readiness, the collaboration process, assessment, priorities, a community plan and budget to reach the desired results for children and their families.

“Developmentally appropriate” means that services are based on human development and learning, individual characteristics and experiences, and social and cultural contexts.

“Early care,” “early care services,” or *“early care system”* means the programs, services, support or other assistance made available to a parent or other person who is involved with addressing the health and education needs of a child from birth through the age of five. “Early care,” “early care services,” or “early care system” includes but is not limited to public and private efforts and formal and informal settings.

“Early childhood business committee” means a committee created by the Iowa board to advise the Iowa board on the use of the first years first account funds and to support implementation of the business community investment advisory council.

“Elected official” means a member of a board or governing body elected through the means of a public election.

“Empowerment area” means a geographic area as defined by the local community and designated by the Iowa board.

“Family support” means community-based services to promote the well-being of children and families.

1. Family support programs have the following characteristics:
 - Family-driven, meaning there is a true partnership with families.
 - Comprehensive, flexible, and individualized to each family based on the family’s culture, needs, values and preferences.
 - Build on strengths to increase the stability of family members and the family unit.
 - Utilize informal and formal support networks.
2. Family support programs produce the following results:
 - Increased parent confidence and competence in their parenting abilities.
 - Safe, stable, and supportive families who are connected to their communities.
 - Enhanced health, growth, and development of children and adults in the family unit.

“First years first” means a public-private partnership for early childhood in Iowa which includes an account created in the Iowa empowerment fund under the authority of the department of management to be used for first years first.

“Fiscal agent” means a public agency as defined in Iowa Code section 28E.2; a community action agency as defined in Iowa Code section 216A.91; a nonprofit corporation; or an area education agency as defined in Iowa Code chapter 273 to be designated as the fiscal agent by a community board.

“Fiscal assessment” means a comprehensive listing of funding to support children prenatal through five years of age.

“Home visitation” means a strategy to deliver family support or parent education services. A home visit is a face-to-face visit with a family in the family’s home or other alternate location to facilitate meeting the family’s goals.

“Indicator” means a measure that indirectly quantifies the achievement of a result.

“*Iowa board*” means the state of Iowa’s community empowerment board as appointed by the governor that meets the membership criteria of citizens and state agency directors as voting members and legislators as nonvoting members.

“*Iowa board advisory council*” means a body of individuals appointed by the Iowa board, including community board members, to obtain input and recommendations on policy and guidelines.

“*Iowa empowerment fund*” means a fund created in the state treasury from which moneys will be distributed to empowerment areas for the purpose of supporting children and their families.

“*Parent education*” means programs that implement organized and planned meetings designed to support parents’ efforts to enhance their children’s health and development. Parent education may be provided in a group setting or one-on-one in a family’s home or alternate location. It is generally limited in scope and duration, typically lasting for 8 to 12 weeks. Parent education programs have the following characteristics:

- Provide parents with information, skills, support systems and confidence in their parental role in order to support, nurture and promote children’s health and development;
- Strengthen positive relationships between parents and children;
- Build on parents’ strengths and utilize their experiences, ideas and knowledge; and
- Provide information that meets the needs of parents for specific content and that is shared in a manner that is responsive to a parent’s learning style, education and culture.

“*Performance measure*” means a measure that assesses a program, activity, or service.

“*Preschool programming support services*” means assistance with preschool tuition not covered by another source for families who have children aged three, four, or five and who meet the eligibility requirements; support for transporting children to and from preschool services; or services that directly enhance or expand existing programming for children.

“*Result*” means the effect desired for Iowans.

“*Results-oriented*” means the focus of the Iowa board and community boards is on results of the effect and impact the community plan and community collaboration have on children and their families for progress toward the desired results.

“*State agency*” means a department of the executive branch including, but not limited to, the departments of economic development, education, human rights, human services, public health, and workforce development.

“*State empowerment team*” means the central office of empowerment in the department of management and identified personnel from the state departments of economic development, education, human rights, human services, public health, and workforce development to provide the day-to-day operational work of local- and state-level community empowerment and support to the Iowa board.

“*Technical assistance*” means an ongoing, systematic and interactive process that is designed to achieve results and that enables knowledge from research, policy and evidence-based practices to be shared in partnerships through a variety of strategies with specific groups, agencies, communities and other partners to use within their unique contexts.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

349—1.5(28) Community empowerment central office.

1.5(1) Structure. The office of empowerment shall be established as a division of the department of management to provide a center for facilitation, communication and coordination for the community empowerment process, associated activities and funding.

1.5(2) Staff shall include a facilitator who is appointed by the governor, subject to confirmation by the senate, and who serves at the pleasure of the governor. A deputy and support staff may be designated. Staff shall be provided by state agencies represented on the Iowa board and by additional state agencies which make staff available.

1.5(3) Responsibility. The central office of empowerment and state empowerment team shall:

- a. Provide primary staffing to the Iowa board.
- b. Coordinate state technical assistance activities.
- c. Implement a technical assistance system. The technical assistance system:

- (1) Utilizes local representatives of state agencies represented on the Iowa board.
 - (2) Utilizes other state agencies and individuals involved with empowerment areas.
 - d.* Communicate and coordinate functions.
 - e.* Increase state- and local-level collaboration.
 - f.* Provide coordination and other support to the state's early care system.
 - g.* Move authority and decision-making responsibility from the state to communities.
 - h.* Compile an annual report to the governor and general assembly on Iowa board activity and policy development, state-level indicators toward desired results and the empowerment area's collaboration process, local indicators and performance measures. The annual report will include progress to avoid duplication, enhance efforts, combine planning and best utilize identified funding to meet the needs of the children and their families in the empowerment areas.
 - i.* Work with the state and local components of the community empowerment initiative and other public and private efforts to improve the early care system.
 - j.* Provide support to the public and private stakeholders who are involved with the early care system, acting to strengthen the early care system and develop accountability measures for early care efforts.
 - k.* Develop and disseminate accountability measures for assessing the outcomes produced by the department of education, the community empowerment initiative, and other publicly funded efforts to improve early care of young children. The initial measures utilized shall be the individual growth and development indicators developed by the early childhood research institute on measuring growth and development or other measures of high quality authorized by law.
 - l.* Collect, interpret, and redisseminate data gathered from the measures for assessing outcomes under paragraph "j." Factors subject to interpretation may include area demographics, relative expenditures, collaboration between programs in an area, and other factors impacting the outcomes produced by an individual program.
 - m.* Annually provide information to the governor and general assembly regarding the outcomes produced by individual programs. The information shall be included in the Iowa board's annual report.
- 1.5(4) Technical assistance.** Funds will be allocated to support the central office of empowerment.
- a.* Technical assistance shall be provided continuously as well as upon request at the state and community level by the state empowerment team and appropriate local providers.
 - b.* State or regional technical assistance may be provided, upon request, to assist in the resolution of a disagreement arising in empowerment areas or community boards.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

349—1.6(28) Iowa board.

1.6(1) Membership. The Iowa board shall consist of 22 voting members: 16 citizen members and 6 state agency director members. Four legislators shall serve as nonvoting members.

- a.* Six members shall be the directors, not the designees, of the state departments of economic development, education, human rights, human services, public health, and workforce development.
- b.* The 16 citizen members shall be appointed by the governor, subject to confirmation by the senate.

(1) Appointments of citizen members shall ensure that each of the state's congressional districts is represented by at least two citizen members.

(2) Citizen members may be reimbursed for actual and necessary expenses incurred in the performance of their duties, and paid a per diem as stated in Iowa Code section 7E.6.

(3) Appointments shall reflect the ethnic, cultural, social, and economic diversity of the state. The governor's appointees shall be selected from individuals nominated by community boards.

(4) Appointments shall reflect the community board membership of one or more members each representing education, health, human services, business, faith, consumer and public interest.

c. Six legislators shall serve as nonvoting members of the Iowa board.

(1) Three legislators shall be appointed by the speaker of the house, with not more than two representing the same political affiliation, following consultation with the majority and minority leaders.

(2) Three legislators shall be appointed by the majority leader of the senate, with not more than two representing the same political affiliation, following consultation with the president of the senate and the minority leader of the senate.

(3) Legislative members are eligible for per diem and expenses as provided in Iowa Code section 2.10.

1.6(2) Structure.

a. The Iowa board shall adopt bylaws to establish structure and function.

(1) The chairperson shall be elected from the citizen members.

(2) A simple majority of the voting membership shall constitute a quorum.

(3) Terms of office of all citizen members are three years.

(4) A vacancy on the board shall be filled in the same manner as the original appointment for the balance of the term.

b. The Iowa board shall meet a minimum of four times during the state fiscal year. Additional meetings may be called upon the request of the chairperson or upon the call of a majority of the voting members.

1.6(3) Iowa board responsibility.

a. The Iowa board may designate an advisory council consisting of representatives from community boards and persons knowledgeable or interested in the fields of health, human services, education and early childhood.

b. The Iowa board shall strive for coordination of services for children and their families through a state and local community partnership.

c. The Iowa board shall provide for maximum flexibility and creativity in the designation and administration of the responsibilities and authority of community boards and empowerment areas.

d. The Iowa board shall adopt guidance for community empowerment in Iowa. The guidance shall include at a minimum:

(1) The following state-level indicators are adopted and indirectly quantify the achievement of the desired results set forth in rule 801—1.2(28):

1. Low birth weight;
2. Immunized children;
3. Preliteracy skills;
4. Children in quality preschools;
5. Incidence of child abuse;
6. Teen births;
7. Crime rate;
8. Juvenile crime;
9. Employment rate;
10. Child abuse in a child care setting;
11. Availability of child care; and
12. Quality child care ratings.

(2) State-level indicators to be measured and available each fiscal year as compared with a baseline and prior fiscal years, as data is available.

(3) A process to request a plan of action from an empowerment area regarding progress toward desired results.

(4) Guidelines for progress reports by empowerment areas, including a process to report progress toward achieving results.

(5) Integration of statewide quality standards and results indicators adopted by other boards and commissions into the Iowa empowerment board's funding requirements for investments in early care, education, health, and human services.

e. The Iowa board shall annually submit results to the governor and general assembly.

f. The Iowa board shall regularly make information available identifying community empowerment funding and funding distributed for purposes of the early care system.

g. The Iowa board shall evaluate and determine empowerment area requests for approval of revised local structure and boundaries.

h. The Iowa board shall develop guidelines for insurance or other liability coverage of community boards.

i. The Iowa board shall, with extensive community input, develop and annually update a five-year and a ten-year plan to assist empowerment areas to reach collaboration and strive to align local assets and resources to reach desired results. The annual plan update will be provided each December to empowerment areas, the governor, and the general assembly.

j. The Iowa board shall identify bodies in state government providing overlapping and similar purposes to the public in early care, education, health, and human service and make recommendations and provide an annually updated strategic plan to the governor and general assembly to improve efficiencies, increase alignment, coordination, consolidation or integration of quality functions to achieve desired results, and for integration of state-administered funding streams directed to community empowerment areas and other community-based efforts for providing early care, education, health, and human service.

k. The Iowa board shall coordinate, consolidate, or integrate community-level committees, coalitions, planning groups, and other bodies with common purposes and memberships formed in response to state requirements.

l. The Iowa board shall evaluate and respond to requests from a community board for consolidation or integration to enhance reaching desired results. In order to implement a waiver, the community boards will follow the current waiver process as identified in administrative rules of each state agency.

m. The Iowa board shall establish a process for designation to occur every three years.

(1) The Iowa board determines the award of designation status to an empowerment area.

(2) The community board evaluates:

1. Community plan;
2. Progress toward local indicators and performance measures;
3. Collaboration process;
4. Management of empowerment funds; and
5. Local system development.

n. The Iowa board shall review annual reports that include indicator data and performance measure data submitted from local areas and may request a plan for corrective action or withdraw grant funding.

o. The Iowa board shall provide for the operation of an Internet Web page for purposes of widely distributing early care information provided by the departments represented on the board and the public and private agencies addressing the early care system.

(1) Information provided on the Internet Web page shall include but not be limited to all of the following:

1. The Iowa early learning standards for children aged birth to three and three to five.
2. A link to a special Web page directed to parents, including parent-specific information on early care and information regarding the early childhood development credits under Iowa Code section 422.12C, and links to other resources available on the Internet and from other sources.
3. Program standards for early care that have been approved by state agencies.
4. A single point of contact for use by a parent in accessing the community empowerment area programs and early care programs that are available in the parent's area.

(2) The Iowa board shall include information regarding the extent and frequency of usage of the Web page in the board's annual report to the governor and general assembly.

p. The Iowa board shall establish an early childhood business committee to serve in an advisory role to the Iowa board on the use of the gifts and grants account funds and to support the implementation of the business community investment advisory council recommendations through first years first.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

349—1.7(28) Empowerment area.

1.7(1) Structure. A large enough population and geographic area exist to efficiently and effectively administer the responsibilities and authority of the community board to enable citizens to lead collaborative efforts involving early care, education, health, and human services on behalf of children, families and other citizens in the empowerment area.

a. A governing board is established to meet criteria for membership and structure and to assume the responsibility of a community board.

b. An empowerment area of a county or school district not meeting required criteria may request an exception to policy from the Iowa board.

1.7(2) Responsibility. An empowerment area is established to enable local citizens to be involved and commit to reaching the desired results for children and their families and to fulfilling the purpose of community empowerment.

349—1.8(28) Community board.

1.8(1) Structure. A community board shall function as the governing board for an empowerment area.

a. Empowerment area functions shall be performed under the authority of a community board.

b. A community board is a unit of local government for purposes of Iowa Code chapter 670, which relates to tort liability of governmental subdivisions.

c. A majority of the members of a community board shall be elected officials or citizens.

d. A community board shall have members to represent, at a minimum, education, health, human services, citizens, elected officials, and business, faith, consumer and public interest.

e. Each community board shall adopt bylaws that will, at a minimum:

(1) Establish the function and structure for community boards.

(2) Set the terms of office for three years, and the terms shall be staggered.

(3) Provide for the election of a chairperson from citizens, elected officials or volunteers.

f. A community board shall establish an organizational structure to ensure that the local expertise, public will and continuous input from the community are requested, reviewed and evaluated.

g. The meetings of a community board or any committee or other body established by a community board at which public business is discussed or formal action taken shall comply with the requirements of Iowa Code chapter 21 (open meetings).

h. A community board shall maintain its records in accordance with Iowa Code chapter 22 (open records).

1.8(2) Responsibility.

a. A community board shall:

(1) Obtain extensive community input to develop a mission and a vision for the empowerment area.

(2) Designate a fiscal agent from a public agency, a community action agency, an area education agency or a nonprofit corporation.

(3) Administer, at a minimum, the community empowerment funds from the state awarded for the empowerment area.

(4) Administer funds as provided by law or from other federal, state, local, grant, foundation, or private moneys or other funds.

(5) Ensure that interest or earnings on the community empowerment funds will be used for services in the community plan.

(6) Coordinate with the decategorization governing boards on the community plan and budget for the empowerment geographic area.

(7) Develop and implement a community plan which addresses sustainability, with identified priorities, current needs, gaps and services, based on community assessments which address early care, human service, education and health needs to support children prenatal through five years of age and their families in reaching desired results. At a minimum, the community plan shall include:

1. A description of current and desired levels of community coordination of services for children prenatal through five years of age, including the involvement and specific responsibilities of all related organizations and entities.

2. A fiscal assessment that identifies federal, state, local and private funding sources and funding amounts available in the empowerment area for use in providing services to children prenatal through five years of age.

3. A description of how funding sources will be used collaboratively and the degree to which the moneys can be combined to provide necessary services to children.

4. Priorities the community board expects to achieve through the implementation of the community plan and the program performance measures to be reported in the annual report.

5. A description of the support services provided in the empowerment area to child care facilities registered or licensed under Iowa Code chapter 237A to prevent the spread of infectious diseases, prevent child injuries, develop health emergency protocols, help with medication, and care for children with special health needs.

6. A process for evaluating progress.

(8) Ensure that an annual report for the empowerment area on the effectiveness of the community plan is submitted each fiscal year on or before September 15 to the Iowa board and to local governing bodies in the empowerment area. The annual report shall:

1. Provide information that identifies existing sources of funding, including in kind and match, and how these funds may be coordinated with the early childhood and school ready funds to support the community plan.

2. Identify members of the community board, including each member's representation.

3. Identify local empowerment area indicators to assess the effectiveness of the community plan. Include baseline data, three years of trend data, data source(s), the linkage to desired results, and data analysis to support the identified indicators.

4. Provide a description of community collaboration within the empowerment area.

5. Provide updates or changes to the community plan.

6. Provide performance measures for programs and activities funded, including state-required measures, through the early childhood and school ready grant funds.

7. Include financial statements for both early childhood and school ready grant funds.

(9) Provide staffing for the empowerment area and community board through the collaborative efforts of public and private organizations committed to reaching desired results for children and their families.

(10) Assume other responsibilities established by law or administrative rule.

b. A community board may:

(1) Designate one or more committees for oversight of empowerment funds awarded to the empowerment area. Committees make recommendations to the community board and have no decision-making authority.

(2) Develop, within the empowerment area, neighborhood bodies for community-level input to the community board and implementation of the community plan. Representatives who serve on these bodies advocate, make recommendations, provide expertise, suggest public policy, and provide guidance to the community board.

(3) Apply to the Iowa board or state agencies for waivers in order to administer categorical funds for services provided in the empowerment area which support the desired results for children and their families.

(4) By mutual written agreement between the community board, the decategorization board, and the state department of human services, assume the duties of the decategorization board, or the decategorization board may serve as a committee of the community board.

(5) Function as a coordinating body for collaboration and alignment of services offered by different entities and directed toward similar purposes within the empowerment area.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

349—1.9(28) Iowa empowerment fund. An Iowa empowerment fund is created in the state treasury as specified in Iowa Code section 28.9. A school ready funding account is created in the Iowa empowerment fund under the authority of the Iowa board to be administered by the director of the department of education. Moneys credited to the account shall be distributed by the department of education to designated empowerment areas pursuant to criteria established by the Iowa board in accordance with law. An early childhood funding account is created in the Iowa empowerment fund and shall be distributed by the director of the department of human services to designated empowerment areas pursuant to criteria established by the Iowa board in accordance with law. A first years first account is created in the Iowa empowerment fund under the authority of the department of management. The account shall consist of gift or grant moneys obtained from any source, including but not limited to the federal government. Moneys credited to the account are appropriated to the department of management to be used for first years first. Interest or earnings on moneys deposited in the Iowa empowerment fund shall be credited to the fund.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

349—1.10(28) Iowa empowerment funds.

1.10(1) Purpose. The purpose of Iowa empowerment funds is to:

- a. Encourage early intellectual stimulation of very young children;
- b. Increase the basic skill levels of students entering school;
- c. Increase the health status of children;
- d. Reduce the incidence of child abuse and neglect;
- e. Increase a family's involvement with the family's children; and
- f. Increase the quality and accessibility of child care and preschool.

1.10(2) Criteria for the use of early childhood funds. Use of early childhood funds is defined in department of human services 441—Chapter 169, Iowa Administrative Code.

1.10(3) Criteria for school ready funds. School ready funds may be provided according to the community plan following community assessment of assets, resources and needs and identification of priorities.

- a. Services in a community plan may include, but are not limited to:
 - (1) Child development services.
 - (2) Child care services.
 - (3) Child care provider training on a child's early learning experience.
 - (4) Children's health and safety.
 - (5) Family support services and parent education.
 - (6) Preschool programming support services.
- b. Up to 3 percent of annual school ready funds may be used by the community board for administrative costs and other implementation expenses.
- c. Empowerment areas shall commit approximately 60 percent of the remainder of school ready funds to family support services and parent education programs targeted to families with children who are prenatal through five years of age based upon a local community needs assessment.
- d. The Iowa board will incorporate statewide quality standards and results indicators adopted by other boards and commissions into the Iowa board's funding requirements for investments in early care, education, health, and human service.
- e. Eligibility to receive school ready funds shall be limited to designated empowerment areas.
- f. School ready funds may be adjusted for other federal and state grant moneys received by the empowerment area.
- g. Distribution of school ready funds shall be in accordance with directives in the current legislative appropriation of these funds.

1.10(4) Criteria for first years first funds. Use of first years first funds is defined in department of management 541—Chapter 13, Iowa Administrative Code. [See ARC 7640B, IAB 3/25/09.]

1.10(5) Method for carryforward of funds. The amount of school ready children grant funding the Iowa empowerment board may carry forward annually shall not exceed 20 percent. School ready children

grant funds received by a community empowerment board in a fiscal year shall be carried forward to the following fiscal year. However, any funds that remain unencumbered and unobligated at the end of the fiscal year in excess of 20 percent of the funds received in a fiscal year shall be subtracted by the Iowa empowerment board from the allocation to the community empowerment board for the following fiscal year.

[ARC 7831B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code chapter 28.

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CHAPTER 4
CAMPAIGN DISCLOSURE PROCEDURES
[Prior to 9/9/87, Campaign Finance Disclosure[190] Ch 4]
[Prior to 3/30/94, Campaign Finance Disclosure Commission[121] Ch 4]

DIVISION I
ORGANIZATIONAL REQUIREMENTS

351—4.1(68A,68B) Requirement to file statement of organization (DR-1)—persons subject to requirements; financial thresholds; where to file; when due.

4.1(1) *Persons subject to requirement.* Every committee shall file a statement of organization (Form DR-1) within ten days from the date of its organization. The forms shall be either typewritten or printed legibly in black ink.

a. "Committee" defined. "Committee" includes the following:

(1) A "candidate's committee" that is the committee, even if the committee consists only of the candidate, designated by a candidate for a state or local office to receive contributions, make expenditures, or incur debts in excess of \$750.

(2) A "political committee" (PAC) that is a committee exceeding the \$750 organizational threshold to expressly advocate the nomination, election, or defeat of candidates or to expressly advocate the passage or defeat of a ballot issue. The board shall automatically classify as a political committee any political organization that loses its status as a political party because it fails to meet the requirements of Iowa Code section 43.2. The board shall automatically classify as a political committee any county central committee that operated under the former political party.

(3) A "state statutory political committee" (state party), "county statutory political party" (county central committee), or "city statutory political committee" (city central committee).

(4) A person that wishes to register a committee for purposes of using the short form "paid for by" attribution statement shall file Form DR-SFA pursuant to rule 351—4.11(68A).

b. When organization occurs; financial thresholds. At the latest, organization is construed to have occurred as of the date that the committee first exceeded \$750 of financial activity in a calendar year in any of the following categories: contributions received (aggregate of monetary and in-kind contributions); expenditures made; or indebtedness incurred.

c. Permanent organizations temporarily engaging in political activity. The requirement to file the statement of organization applies to an entity that comes under the definition of a "political committee" (PAC) in Iowa Code Supplement section 68A.102(18) by receiving contributions, making expenditures, or incurring debts in excess of \$750 in any one calendar year for the purpose of expressly advocating the election or defeat of a candidate for public office, or for the purpose of expressly advocating the passage or defeat of a ballot issue. A permanent organization that makes a one-time contribution in excess of \$750 may in lieu of filing a statement of organization follow the procedure in rule 351—4.35(68A). A permanent organization that makes loans to a candidate or committee or that is owed debts from a candidate or committee is not deemed to be engaging in political activity requiring registration.

4.1(2) *Place of filing.* Statements of organization shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. Statements may also be filed by fax at (515)281-3701 or filed electronically through the board's Web site at www.iowa.gov/ethics.

4.1(3) *Time of filing.* A statement of organization shall be filed with the board within ten days after the financial filing threshold in subrule 4.1(1) has been exceeded. A statement must be physically received by the board or, if mailed, must bear a United States Postal Service postmark dated on or before the report due date. Faxed or electronically filed statements must be submitted on or before 11:59 p.m. of the tenth day after the organization of the committee is required. If the tenth day falls on a Saturday, Sunday, or holiday on which the board office is closed, the filing deadline is extended to the next working day when the board office is open.

4.1(4) *Candidate defined.* For purposes of Iowa Code chapters 68A and 68B and the rules of the board, "candidate" means an individual who takes affirmative action to seek nomination or election to a state or local public office. For purposes of Iowa Code chapter 68A and any rules of the board on

campaigning for public office, “candidate” includes any judge or judicial employee who is required by law to stand for retention. “Takes affirmative action” includes making a public announcement of intention to seek nomination or election, making any expenditure or accepting any contribution for nomination or election, distributing petitions for signatures for nomination, filing nomination papers or an affidavit of candidacy, or being nominated by any convention process set out by law.

4.1(5) *Ballot issue defined.* “Ballot issue” means a question that has been approved by a political subdivision or the general assembly to be placed before the voters or is otherwise required by law to be placed before the voters. “Ballot issue” does not include the nomination, election, or defeat of a candidate.

This rule is intended to implement Iowa Code Supplement sections 68A.201 and 68A.401.

351—4.2(68A,68B) Information required: committee name.

4.2(1) *Full name required.* The statement of organization shall include the full name of the committee. A committee using an abbreviation or acronym as part of the committee name shall provide with the statement of organization a written explanation of the full word or words that are abbreviated or that form the acronym.

4.2(2) *Duplication of name prohibited.* The committee name shall not duplicate the name of another committee organized under Iowa Code chapter 68A. The board shall determine whether two committee names are in duplication in violation of Iowa Code section 68A.201(2)“a.” A committee duplicating the name of another organized committee shall choose a new committee name upon notification from the board. A candidate who files an amended statement of organization to reflect a change in office sought shall not be required to change the name of the candidate’s committee unless the committee’s name duplicates the name of another organized committee. A committee shall not duplicate the name of a dissolved committee for a period of ten years after the dissolved committee is certified as being dissolved except when the candidate for both committees is the same individual.

4.2(3) *Candidate’s surname required in committee name.* A candidate filing a statement of organization on or after July 1, 1995, shall include the candidate’s surname within the committee name. This requirement also applies to a new candidate’s committee organized by a candidate who has a preexisting candidate’s committee but who organizes a new candidate’s committee or files an amended statement of organization.

This rule is intended to implement Iowa Code Supplement section 68A.201.
[ARC 7646B, IAB 3/25/09, effective 4/29/09]

351—4.3(68A,68B) Information required: committee purpose; party affiliation.

4.3(1) *Committee purpose.* An organized campaign committee shall identify the purpose of the committee on the statement of organization. The purpose shall be indicated in part by designating the committee as one of the following types of committees:

Type 1 - A candidate’s committee for a statewide or legislative candidate or a judge standing for retention. This type of committee is referred to as a state candidate’s committee.

Type 2 - A political committee that expressly advocates for or against candidates at the state level or expressly advocates for or against a statewide ballot issue. This type of committee is referred to as a statewide PAC.

Type 3 - A state statutory political committee. This type of committee is referred to as a state party.

Type 4 - A county statutory political committee. This type of committee is referred to as a county central committee.

Type 5 - A candidate’s committee for a candidate seeking county office. This type of committee is referred to as a county candidate’s committee.

Type 6 - A candidate’s committee for a candidate seeking city office. This type of committee is referred to as a city candidate’s committee.

Type 7 - A candidate’s committee for a candidate seeking school board or other political subdivision office except for a county or city office. This type of committee is referred to as a school board or other political subdivision candidate’s committee.

Type 8 - A political committee that expressly advocates for or against candidates for county office. This type of committee is referred to as a county PAC.

Type 9 - A political committee that expressly advocates for or against candidates for city office. This type of committee is referred to as a city PAC.

Type 10 - A political committee that expressly advocates for or against candidates for school board or other political subdivision except for county or city candidates. This type of committee is referred to as a school board or other political subdivision PAC.

Type 11 - A political committee that expressly advocates for the passage or defeat of a ballot issue, franchise election, or referendum conducted for a county, city, school, or other political subdivision ballot question. This type of committee is referred to as a local ballot issue committee.

4.3(2) Party affiliation. A candidate's committee is deemed to be established to expressly advocate the election of a candidate for public office. Each candidate's committee shall designate the political affiliation of the candidate. Any other committee shall designate that it is either established to expressly advocate the election or defeat of candidates or the passage or defeat of a ballot issue.

This rule is intended to implement Iowa Code Supplement section 68A.201.

351—4.4(68A,68B) Information required: officers; committee information; signatures.

4.4(1) Committee officers. The committee shall disclose on the statement of organization the name, mailing address, telephone number, and office of each committee officer whom the committee is required by statute to appoint. Each candidate's committee shall appoint a treasurer who shall be an Iowa resident and at least 18 years of age. Every other committee shall appoint a separate treasurer and chairperson, each of whom shall be at least 18 years of age. The committee may appoint other officers not required by statute without restriction on residency or age, and the committee is not required to disclose these officers. Except for a candidate's committee, every committee shall either have an Iowa resident as treasurer or shall maintain all of the committee's funds in bank accounts in a financial institution in Iowa.

4.4(2) Committee address and telephone number. The address and telephone number of the candidate as indicated on the statement of organization shall be the official address and telephone number to be used for communication from the board to the candidate's committee. The address and telephone number of the committee chairperson as indicated on the statement of organization shall be the official address and telephone number to be used for communication from the board to every other committee except for a candidate's committee. If an electronic mail address has been provided on the statement of organization, communication from the board to a committee shall be sent by electronic mail.

4.4(3) Signatures. The candidate and treasurer shall sign the statement of organization filed by a candidate's committee. The chairperson and treasurer shall sign a statement of organization filed by any other type of committee. A statement of organization filed electronically using the board's Web site is deemed signed when filed.

This rule is intended to implement Iowa Code Supplement section 68A.201.

351—4.5(68A,68B) Segregation and timely deposit of funds; information required: identification of financial institution, account name; notice to treasurer.

4.5(1) Segregation and deposit of funds. All committee funds shall be maintained in a financial institution and shall be segregated from any other funds held by a candidate, officer, member, or associate of the committee. The committee treasurer shall deposit all contributions within seven days of receipt by the treasurer in an account maintained by the committee.

4.5(2) Exception from segregation of committee funds. A candidate's committee that receives contributions only from the candidate is not required to maintain a separate account. A permanent organization temporarily engaging in activity that qualifies it as a political committee that uses existing general operating funds and does not solicit or receive funds from other sources for campaign purposes is not required to maintain a separate account.

4.5(3) Identification of financial institution and account. The committee shall disclose on the committee's statement of organization the name and mailing address of all financial institutions in

which committee funds are maintained. The committee shall also disclose the name and type of all accounts in which committee funds are maintained, and the name of any such account shall be the same as the committee name on the statement of organization.

4.5(4) Notice to treasurer. Any person who receives contributions for a committee shall render the contributions to the treasurer within 15 days of receipt and provide the committee treasurer with the reporting information required by Iowa Code Supplement section 68A.203(2).

This rule is intended to implement Iowa Code Supplement sections 68A.201 and 68A.203.

351—4.6(68A,68B) Amendments to statement of organization; requirement for new statement of organization for new office sought.

4.6(1) Amendment within 30 days. If there is a change in any of the information disclosed on a statement of organization, the committee shall file an amended statement within 30 days of the change. An amended statement of organization shall be filed with the board and the board shall make available to the appropriate county commissioner of elections an amended statement filed by a county, city, school, or other political subdivision committee.

4.6(2) New office sought. A candidate who filed a statement of organization for one office but eventually seeks another office may file an amended statement of organization to reflect the change in office sought in lieu of dissolving the old committee and organizing a new committee. A candidate filing an amended statement of organization for a new office shall continue to file the required campaign reports regardless of whether the \$750 financial filing threshold for the new office has been exceeded. A candidate who has filed a statement of organization for one office and who then exceeds the financial activity threshold as set forth in Iowa Code section 68A.102(5) for a new office shall, within ten days of exceeding the threshold, file either an amended statement of organization disclosing information for the new office sought or organize and register a new committee.

This rule is intended to implement Iowa Code Supplement section 68A.201.

DIVISION II
REPORTING AND FINANCIAL TRANSACTION REQUIREMENTS

351—4.7(68A,68B) Disclosure reporting required; information on initial report; minimum filing if no activity.

4.7(1) Disclosure reporting required. Every committee that has filed a statement of organization under Iowa Code section 68A.201 and rule 351—4.1(68A,68B) or has exceeded the financial activity threshold set out in Iowa Code section 68A.102(5) or (18) prior to the cutoff date for reporting campaign transactions shall file a campaign disclosure report pursuant to Iowa Code section 68A.402.

4.7(2) Information on initial report. The first disclosure report filed by a committee shall include the relevant financial information covering the period from the beginning of the committee's financial activity through the end of the current reporting period.

4.7(3) Funds available from prior committee. If funds are available to a candidate's committee from a prior candidacy of that candidate, or to a ballot issue committee from a prior effort on a ballot issue, and the prior candidacy or effort had not exceeded the financial reporting threshold, the carryover balance shall be disclosed by the new committee. The disclosure shall be made on Schedule A - Contributions and shall include the amount of the carryover, the date of the prior election, and the name and address of any source that made contributions to the candidacy or ballot effort that totaled more than \$750 during the preceding three calendar years.

4.7(4) Funds available from preballot issue activity. Funds that are raised for an activity that is not included in the definition of a ballot issue in Iowa Code Supplement section 68A.102(1) and that are made available to a subsequent ballot issue committee shall be disclosed by the committee. The disclosure shall be made on Schedule A - Contributions and shall include the amount of the carryover balance, the date of the preballot issue activity, and the name and address of any source that made contributions to the activity that totaled more than \$750 during the previous three calendar years.

4.7(5) *No financial activity during reporting period.* A committee that did not have any financial activity during the relevant reporting period for which a disclosure report is due shall be required to file only Form DR-2. However, if the committee had previously disclosed debts or loans, those obligations shall again be disclosed on either Schedule D - Incurred Indebtedness or Schedule F - Loans Received and Repaid, as appropriate, and the schedule or schedules shall be included with Form DR-2. A candidate's committee that has reportable campaign property under Iowa Code Supplement section 68A.304 shall disclose the property on Schedule H - Campaign Property and the schedule shall be included with Form DR-2.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.8(68A,68B) Disclosure reporting required—where reports filed.

4.8(1) *Place of filing.* Disclosure reports shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. Reports may also be filed by fax at (515)281-4073, as an E-mail attachment, or electronically through the board's Web site at www.iowa.gov/ethics.

4.8(2) *Reports made available.* The board shall post on its Web site at www.iowa.gov/ethics all statements and reports filed under Iowa Code chapter 68A.

4.8(3) *Records retention.* The board shall maintain and retain all statements and reports filed under Iowa Code chapter 68A under the applicable provisions of Iowa Code chapter 305.

This rule is intended to implement Iowa Code section 68A.401 as amended by 2007 Iowa Acts, Senate File 39, section 5, and 2007 Iowa Acts, House File 413, section 1.

351—4.9(68A) Campaign disclosure report due dates.

4.9(1) *Statewide office, general assembly, judge standing for retention.* A candidate's committee of a candidate for statewide office or the general assembly or a judge standing for retention shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 or Wednesday preceding primary election* through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 or Wednesday preceding general election* through December 31 of election year

b. Supplementary report.

<u>Report due</u>	<u>Covering period</u>
Friday preceding primary election*	May 15 through Tuesday preceding primary election*
Friday preceding general election*	October 15 through Tuesday preceding general election*

*If supplementary report required. See subrule 4.9(2).

c. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

d. Special election.

<u>Report due</u>	<u>Covering period</u>
Five days preceding the election*	Date of initial activity through tenth day prior to the special election

*This report is in addition to the election year reports required under paragraph 4.9(1) "a."

4.9(2) Statewide office or general assembly—supplementary reports. In addition to reports required under subrule 4.9(1), a supplementary report is required if contributions received during the period beginning on the date of initial financial activity, or the day after the period covered by the last report, as applicable, through the Tuesday preceding the primary or general election equal or exceed the following thresholds:

<u>Office sought</u>	<u>Contribution threshold</u>
Governor	\$10,000 or more
Other statewide office	\$5,000 or more
General assembly	\$1,000 or more

4.9(3) County candidate. A candidate's committee of a candidate for county office shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 through December 31 of election year

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

c. Special election.

<u>Report due</u>	<u>Covering period</u>
Five days preceding the election*	Date of initial activity through tenth day prior to the special election

*This report is in addition to the election year reports required under paragraph 4.9(3) "a."

4.9(4) City candidate. A candidate's committee of a candidate for city office shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
Five days before primary election	Date of initial activity through ten days before primary election
Five days before general election	Nine days before primary election through ten days before general election
Five days before runoff election*	Nine days before the general election through ten days before the runoff election
January 19 (next calendar year)	Cutoff date from previously filed report through December 31

*If a runoff election is held.

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

c. Special election.

<u>Report due</u>	<u>Covering period</u>
Five days preceding the election*	Date of initial activity through tenth day prior to the special election
*This report is in addition to the election year reports required under paragraph 4.9(4) "a."	

4.9(5) School board or other political subdivision. A candidate's committee of a candidate for school board or other political subdivision office, except for county office or city office, shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
Five days before election	Date of initial activity through ten days before election
January 19 (next calendar year)	Nine days before election through December 31

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

c. Special election.

<u>Report due</u>	<u>Covering period</u>
Five days preceding the election*	Date of initial activity through tenth day prior to the special election
*This report is in addition to the election year reports required under paragraph 4.9(5) "a."	

4.9(6) State statutory political committee (state political party). A committee defined in Iowa Code Supplement section 68A.102(22) as a state statutory political committee shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 through December 31 of election year

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(7) County statutory political committee (county central committee). A committee defined as a county statutory political committee in Iowa Code Supplement section 68A.102(12) shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 through December 31 of election year

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(8) State political committee (state PAC). A political committee expressly advocating the nomination, election, or defeat of candidates for statewide office or the general assembly or a judge standing for retention shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 through December 31 of election year

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
July 19	January 1 through June 30
January 19 (next calendar year)	July 1 through December 31

4.9(9) County political committee (county PAC). A political committee expressly advocating the nomination, election, or defeat of candidates for county office shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
May 19	January 1 through May 14
July 19	May 15 through July 14
October 19	July 15 through October 14
January 19 (next calendar year)	October 15 through December 31 of election year

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(10) City political committee (city PAC). A political committee expressly advocating the nomination, election, or defeat of candidates for city office shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
Five days before primary election	Date of initial activity through ten days before primary election
Five days before general election	Nine days before primary election through ten days before general election
Five days before runoff election*	Nine days before the general election through ten days before runoff election
January 19 (next calendar year)	Cutoff date from previously filed report through December 31

*If a runoff election is held.

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(11) *School board or other political subdivision political committee (school board or other local PAC).* A political committee expressly advocating the nomination, election, or defeat of candidates for school board or other political subdivision office, except for county office or city office, shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
Five days before election	Date of initial activity through ten days before election
January 19 (next calendar year)	Nine days before election through December 31

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(12) *Statewide or local ballot issue committee (ballot issue PAC).* A committee expressly advocating the passage or defeat of a statewide or local ballot issue shall file campaign disclosure reports as follows:

a. Election year.

<u>Report due</u>	<u>Covering period</u>
Five days before election	Date of initial activity or previous report through ten days before election
May 19	Date of initial activity or previous report through May 14
July 19	Date of initial activity or previous report through July 14
October 19	Date of initial activity or previous report through October 14
January 19 (next calendar year)	Cutoff date from previously filed report through December 31

b. Nonelection year.

<u>Report due</u>	<u>Covering period</u>
January 19 (next calendar year)	January 1 through December 31 of nonelection year

4.9(13) *Permanent organizations.* A permanent organization temporarily engaging in political activity as described in Iowa Code Supplement section 68A.102(18) shall organize a political committee and shall keep the funds relating to that political activity segregated from its operating funds. The committee shall file reports on the applicable due dates as required by this rule. The reports shall identify the source of the original funds used for a contribution made to a candidate or a candidate's committee. When the permanent organization ceases to be involved in the political activity, the permanent organization shall dissolve the political committee. "Permanent organization" means an organization that is continuing, stable, and enduring, and was originally organized for purposes other than engaging in election activities.

4.9(14) *Election year defined.* "Election year" means a year in which the name of the candidate or ballot issue appears on a ballot to be voted on by the electors of the state of Iowa. For state and county statutory political committees, "election year" means a year in which primary and general elections are held.

This rule is intended to implement Iowa Code section 68A.402.

351—4.10(68A,68B) Time of filing. A report must be physically received by the board or, if mailed, shall bear a United States Postal Service postmark dated on or before the report due date. Faxed,

E-mailed, or electronically filed reports must be submitted on or before 11:59 p.m. of the report due date. However, as provided in Iowa Code Supplement section 68A.402 as amended by 2008 Iowa Acts, Senate File 2400, sections 24 and 28, any report that is required to be filed five days or less prior to an election must be physically received by the board prior to 4:30 p.m. on the report due date. If the due date falls on a Saturday, Sunday, or holiday on which the board office is closed, the due date is extended to the first working day when the board office is open.

This rule is intended to implement Iowa Code Supplement section 68A.402 as amended by 2008 Iowa Acts, Senate File 2400, sections 24 and 28.

351—4.11(68A) Voluntary registration—Form DR-SFA.

4.11(1) *Persons voluntarily registering a committee.* A person that has not exceeded the \$750 financial filing threshold may file Form DR-SFA for purposes of using the short form “paid for by” attribution statement under Iowa Code section 68A.405 and rule 351—4.38(68A). A person using the short form “paid for by” attribution statement shall file Form DR-SFA with the board prior to distributing the political material containing the short form “paid for by” attribution statement.

4.11(2) *\$750 threshold later exceeded.* A person filing Form DR-SFA shall not be required to file a statement of organization or be required to file disclosure reports unless the \$750 threshold is later exceeded. A person that later exceeds the \$750 threshold and that fails to timely file a statement of organization or to timely file disclosure reports may be subject to the appropriate board sanctions as set out by statute and board rule.

This rule is intended to implement Iowa Code sections 68A.201 and 68A.405.

351—4.12(68A,68B) Exception from reporting requirement—reports due within five days of one another. When two disclosure reports are due from the same committee within five days of each other, the activity may be combined into one report. A committee choosing this option shall file a report on or before the second due date that covers the extended reporting period.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.13(68A,68B) Report forms—summary page (DR-2) and supporting schedules. The board may require committees to submit relevant information not specifically delineated in Iowa Code Supplement chapter 68A on their disclosure report where the report form asks for and leaves space for information. All information shall be pertinent to the duties of the board.

4.13(1) *Official reporting forms.* The disclosure reporting forms provided by the board shall be the official forms on which the disclosure reports shall be submitted. Machine copies of original report forms are acceptable. The standard forms for campaign disclosure reports are:

- DR-2 — Disclosure Summary Page
- Schedule A — Monetary Receipts
- Schedule B — Monetary Expenditures
- Schedule C — (Reserved)
- Schedule D — Incurred Indebtedness
- Schedule E — In-kind Contributions
- Schedule F — Loans Received and Repaid
- Schedule G — Consultant Activity
- Schedule H — Campaign Property

4.13(2) *Computer-generated reports.* Committees may generate a disclosure report in lieu of using a board-approved paper report or the board’s electronic filing system so long as the generated report contains the same information and is in the same basic format as a board-approved paper report. Committees generating their own reports must submit the reports for prior board approval before use.

4.13(3) *Typewritten or legible ink reports required.* Information which is provided on all forms shall be either typewritten or printed legibly in black ink. Approved computer-generated reports satisfy this requirement.

4.13(4) *Special information required for city, school, or local ballot issue elections.* Committees expressly advocating the election or defeat of a candidate for city or school public office, or expressly advocating the passage or defeat of a local ballot issue, shall indicate in the designated spaces on the report summary page the date that the election is to be held, the period covered by the disclosure report, and the control county responsible for conducting the election.

4.13(5) *Signature on DR-2 Report Summary Page.* A disclosure report shall be signed by the individual filing the report. A disclosure report filed electronically using the board's Web site is deemed signed when filed.

This rule is intended to implement Iowa Code Supplement sections 68A.402 and 68A.403.

351—4.14(68A,68B) Schedule A - Monetary Receipts.

4.14(1) *Reporting of all monetary receipts; chronological listing.* The committee shall report the amounts of all monetary receipts which are accepted by the committee during the reporting period. If a contribution is returned to a contributor prior to the end of the reporting period and is not deposited into the committee's bank account, the contribution is deemed to have been rejected and shall not be reported. A contribution which is physically received and either deposited into the committee's account or not returned by the end of the reporting period is deemed to have been accepted. The schedule entries shall be listed in chronological order by the date on which the contribution is received.

4.14(2) *Date of contribution—date received.* The schedule shall include the complete date (month/day/year) that the contribution was physically received by a person on behalf of the committee. If the contribution is by check, the date of the contribution to be reported is the date the check is physically received by a person on behalf of the committee, even if this date is different from the date shown on the check. For contributions received by mail, the date of the contribution to be reported shall be the date that the recipient physically opens the envelope.

4.14(3) *Name and address of contributor; joint accounts.* The schedule shall include the name and address of each person who has made one or more contributions of money to the committee if the aggregate amount of contributions (either monetary or in-kind) received from that person in the calendar year exceeds \$25, except that the itemization threshold is \$200 for a state statutory political committee and \$50 for a county statutory political committee. In the case of a contribution by check, the contributor name on the disclosure report shall be the name shown as the account name on the account, except that if the check is on a joint account, the contribution shall be presumed to be from the person who signs the check. If the committee chooses to itemize contributions that are less than the required itemization threshold, it may do so, but shall either do so for all contributions or none of the contributions under the threshold.

4.14(4) *Unitemized contributions and freewill donations.* If the committee does not choose to itemize all contributions under the itemization threshold (\$25 for most committees, see Iowa Code Supplement section 68A.402(3) "b"), it shall aggregate these contributions and report the aggregate amount as "unitemized contributions." No date received is required to be provided for miscellaneous unitemized contributions. Unitemized contributions may be solicited and received through a freewill donation such as a "fish bowl" or "pass the hat" collection if the collection is in compliance with rule 351—4.30(68A,68B). Unitemized contributions collected through freewill donations (the net amount of the collection after the itemization of those persons whose contributions of more than \$10 in the freewill collection resulted in exceeding the annual itemization threshold) shall be reported by showing the net amount as "unitemized contributions—pass the hat (or can collection or fish bowl, for example) collection." The "date received" to be reported for a freewill donation is the date a representative of the committee takes possession of the proceeds of the collection.

4.14(5) *Relationship to candidate.* In the case of contributions to candidates' committees, the schedule shall include information indicating whether the contributor is related to the candidate within the third degree of consanguinity or affinity. "Consanguinity" means a relative through descent from common ancestors (by blood). "Affinity" means a relative through a current marriage. A husband has the same relation, by affinity, to his wife's blood relatives as she has to them by consanguinity and vice versa. "Degree of kinship" is determined by counting upward from one of the persons in question to the

nearest common ancestor, and then down to the other person, calling it one degree for each generation in the ascending as well as the descending line. Under this rule, a woman's sister is related to her by consanguinity in the second degree. The sister is thus related to the woman's husband by affinity in the second degree. Other examples of relationships within the third degree between a contributor and a candidate would be the following: children and stepchildren (first degree); siblings and half-siblings (second degree); grandparents (second degree); grandchildren (second degree); aunts and uncles (third degree); nieces and nephews (third degree); great-grandparents (third degree) and great-grandchildren (third degree), all irrespective of whether the blood relationship is to the candidate or to the candidate's spouse.

4.14(6) ID number and check number. If a contribution to a statewide or general assembly candidate or a judge standing for retention is from a statewide political committee (PAC) or a state party committee, the candidate receiving the contribution shall include on the candidate's disclosure report the board-assigned identification number of the contributing committee and the check number by which the contribution was made. A list of ID numbers may be obtained from the board and is also available on the board's Web site at www.iowa.gov/ethics.

4.14(7) Fund-raiser income. Contributions arising from the sale of goods or services at a fund-raising event shall be designated by marking the indicated space on the schedule.

4.14(8) Interest and other monetary receipts other than contributions. If the monetary receipt is not a "contribution," the name and address of the source of the funds shall be identified in the space provided for the name and address of "contributor," with a notation as to the purpose of the payment, such as "bank interest."

4.14(9) Reverse entries—refunds. If a committee determines to decline or otherwise return a contribution after it has been received, accepted, and deposited, the committee may issue a refund to the contributor, which shall be reported on Schedule A as a reverse entry, reducing the monetary receipts.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.15(68A,68B) Schedule B - Monetary Expenditures.

4.15(1) Date expended. The committee shall report the amounts of all itemized expenditures (expenditures of \$5 or more) made by the committee for the reporting period chronologically by the date expended. The date of the expenditure is the date the check is issued. The complete date (month/day/year) shall be provided.

4.15(2) Name and address of recipient. The schedule shall include the name and address of each person to whom disbursements, other than loan repayments, were made during the reporting period. (Loan repayments shall be reported on Schedule F.)

4.15(3) Purpose of expenditure. The schedule shall include a description of the purpose of each disbursement. The description shall be a clear and concise statement that specifically describes the transaction which has occurred. The following general terms are examples of descriptions which are not acceptable: "expenses," "reimbursement," "candidate expense," "services," "supplies," and "miscellaneous expense." The following are examples of acceptable descriptions: "printing—candidate yard signs," "printing—PAC membership solicitation letter," "mailing—candidate brochures," "reimbursement for candidate lodging to attend campaign event," or "mileage reimbursement—150 miles @ 25¢ per mile." A combined description is not acceptable unless sufficient information is provided so that the cost of separate purposes can be discerned, for example, "printing and mailing of 1,000 brochures."

4.15(4) Miscellaneous (unitemized) expenses. Notwithstanding the other provisions of this rule, disbursements of less than \$5 may be shown as miscellaneous disbursements or expenses for the period so long as the aggregate miscellaneous disbursements to any one person during a calendar year do not exceed \$100.

4.15(5) Candidate ID number and committee check number. If a contribution is made by a statewide political committee (PAC) or a state party committee to a statewide or general assembly candidate or a judge standing for retention, the committee making the contribution shall include on the committee's disclosure report the board-assigned identification number of the recipient candidate's committee and

the check number by which the contribution was made. A list of candidate ID numbers may be obtained from the board and is also available on the board's Web site at www.iowa.gov/ethics.

4.15(6) *Check transactions required.* All disbursements, including all expenditures and any other withdrawals from committee funds, shall be by check. Cash withdrawals and "petty cash" accounts are not permitted. Committees' activities which necessitate cash drawers or other cash transactions shall be conducted and reported as provided by rule 351—4.36(68A,68B).

4.15(7) *Reverse entries—refunds.* If a committee receives a refund of all or part of a disbursement previously made, the committee shall report the refund on Schedule B as a reverse entry, reducing the monetary expenditures. The purpose should include an explanation as to why the refund was made.

4.15(8) *Interest paid; bank charges.* Although repayments of loan principal are reported on Schedule F (see rule 351—4.18(68A,68B)), interest payments on loans shall be reported on Schedule B. Bank service charges and fees (e.g., monthly service fees, costs for check printing, returned check charges) shall also be reported and identified on Schedule B.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.16(68A,68B) Schedule D - Incurred Indebtedness.

4.16(1) *Reporting of debts and obligations other than monetary loans.* The committee shall report all debts and obligations owed by the committee which are in excess of the thresholds in subrule 4.14(3). This applies to any unpaid debt or obligations incurred by the committee for the purchase of a good or service, either as a debt or obligation owed to the immediate provider of the good or service, or as a debt or obligation owed to an individual who initially personally paid for the good or service on behalf of the committee with the expectation of ultimately receiving reimbursement from the committee. However, monetary loans to the committee (which are deposited directly into the committee's account) shall be reported on Schedule F, not on Schedule D.

4.16(2) *Date incurred; balance owed.* The committee shall report the amounts of all indebtedness owed by the committee at the end of the reporting period, reported chronologically by the date incurred. The date the debt or obligation is incurred is the date on which the committee committed to obtaining the good or service underlying the obligation. This date may be earlier than the date the provider of the good or service issues a bill to the committee. For example, if the committee places a printing order, but the printer does not issue a bill until some time after the order is placed, the date which shall be reported as the date the debt was incurred is the date the order is placed, not the date the bill was issued. If the precise amount of the final bill is not known by the time the report is due, the committee shall provide its best estimate as to what the obligation will be, with an indication "(e)" that the amount reported is an estimate. The complete date (month/day/year) shall be provided. Debts and obligations incurred and reported in a prior reporting period but which remain unpaid as of the end of the current reporting period shall be included, showing the remaining balance on the obligation, as well as any new obligations incurred in the current reporting period. Payments of all or part of a previously reported obligation shall be reported as expenditures on Schedule B.

4.16(3) *Name and address of person to whom the debt or obligation is owed.* The schedule shall contain the name and address of each person to whom an obligation is owed, including both those obligations which were incurred during the reporting period and those outstanding obligations which are being carried forward from prior reports. If the obligation is owed to an individual who initially personally paid for the good or service on behalf of the committee with the expectation of ultimately receiving reimbursement from the committee, the original nature of the obligation shall be provided; the name and address of the original provider of the good or service shall also be provided, unless the nature of the obligation indicates that the obligation is for the anticipated reimbursement for mileage or postage stamps.

4.16(4) *Nature of obligation.* The schedule shall include a description of the nature of each obligation. The description shall be a clear and concise statement that specifically describes the transaction which has occurred. The following general terms are examples of descriptions which are not acceptable: "expenses," "reimbursement," "candidate expense," "services," "supplies," and "miscellaneous expense." The following are examples of acceptable descriptions: "printing—candidate

yard signs,” “printing—PAC membership solicitation letter,” “mailing—candidate brochures,” “anticipated reimbursement for candidate lodging to attend campaign event,” or “anticipated mileage reimbursement—150 miles @ 25¢ per mile.” A combined description is not acceptable unless sufficient information is provided so that the cost of separate purposes can be discerned, for example, “printing and mailing of 1,000 brochures.”

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.17(68A,68B) Schedule E - In-kind Contributions.

4.17(1) Reporting of all in-kind contributions; chronological listing. The committee shall report the amounts of all in-kind contributions which are accepted by the committee during the reporting period. The schedule entries shall be listed in chronological order by the date on which the contribution is received.

4.17(2) Date of contribution—date received. The schedule shall include the complete date (month/day/year) on which the in-kind contribution was physically received by a person on behalf of the committee.

4.17(3) Name and address of contributor. The schedule shall include the name and address of each person who has made one or more in-kind contributions to the committee if the aggregate amount of contributions (either monetary or in-kind) received from that person in the calendar year exceeds \$25, except that the itemization threshold is \$200 for a state statutory political committee and \$50 for a county statutory political committee.

4.17(4) Relationship to candidate. In the case of in-kind contributions to candidates’ committees, the schedule shall include information indicating whether the contributor is related to the candidate within the third degree of consanguinity or affinity, as defined in subrule 4.14(5).

4.17(5) Description of in-kind contribution; loaned equipment as in-kind contribution.

a. The schedule shall include a description of the good or service contributed to the committee in kind. The description shall be a clear and concise statement that specifically describes the transaction which has occurred.

b. A committee’s use of equipment owned by another organization, committee, or individual is reportable as an in-kind contribution. Equipment includes, but is not limited to, typewriters, calculators, copy machines, office furniture, computers and printers.

4.17(6) Fair market value. The committee shall provide either the actual (if known) or estimated fair market value of the good or service received.

4.17(7) Fund-raiser item. Goods or services contributed in kind for sale at a fund-raising event shall be designated by marking the indicated space on the schedule.

4.17(8) Unitemized contributions. Notwithstanding the other provisions of this rule, in-kind contributions with a fair market value less than the itemization threshold noted in subrule 4.17(3) may be reported as “unitemized in-kind contributions.”

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.18(68A,68B) Schedule F - Loans Received and Repaid.

4.18(1) Reporting of monetary loans (not debts and obligations for goods and services). The committee shall report all loan activity made to or repaid by the committee during the reporting period. This applies to any loan of money which is deposited into the committee’s accounts. However, other debts and obligations owed for the provision of goods or services to the committee (which are not monetary advances deposited into the committee’s account) shall be reported on Schedule D, not on Schedule F.

4.18(2) Report of lump sum of unpaid loans carried over from last report. The schedule shall contain a beginning entry of the total unpaid loans as of the last report. Loans received and itemized on prior reports should not be re-itemized on the current report, except as necessary to indicate repayment activity.

4.18(3) Date received. The schedule shall include the complete date (month/day/year) the loan was physically received by a person on behalf of the committee. If the loan was by check, the date of the

loan to be reported is the date the check is physically received by a person on behalf of the committee, even if this date is different from the date shown on the check.

4.18(4) *Date paid.* The schedule shall include the complete date (month/day/year) a full or partial loan repayment is made by the committee. The date of the repayment is the date the check is issued. Full or partial loan repayments shall be shown on this schedule and should not be reported on Schedule B. However, loan interest payments shall be reported on Schedule B (see rule 351—4.15(68A,68B)) and not on Schedule F. Loans which may be and are forgiven in full or in part are considered in-kind contributions and shall be itemized on Schedule E, with a cross-reference entry in the space provided on Schedule F.

4.18(5) *Name and address of lender.* The schedule shall include the name and address of each person who has made one or more loans of money to the committee during the reporting period, or to whom the committee makes a full or partial loan repayment during the reporting period. If the person who made the loan to the committee is not the original source of the money, when the original source of the money is a third party (such as a bank which loans money to an individual who loans it to the committee) or if a third party has personally paid and assumed a loan from the original lender (such as an individual who pays off the loan to the bank with the expectation of receiving the loan repayment from the committee), the report shall also identify the name and address of the third party.

4.18(6) *Relationship to candidate.* In the case of monetary loans to candidates' committees, the schedule shall include information indicating whether the lender is related to the candidate within the third degree of consanguinity or affinity, as defined in subrule 4.14(5).

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.19(68A) Schedule G - Breakdown of Monetary Expenditures by Consultants. A committee that enters into a contract with a consultant for future or continuing performance shall be required to report expenditures made to the consultant and the nature of the performance of the consultant that is expected to be received by the committee. A committee is required to report in Part 1 of Schedule G any contracts with consultants that it has negotiated, the complete name and address of the consultant, the period of time during which the contract is in effect, and estimates of performance to be derived from the contract. Expenditures made to the consultant during a reporting period shall be reported with all other expenditures on Schedule B, and debts incurred with the consultant during the reporting period shall be reported with all other debts on Schedule D. Additionally, a detailed breakdown of the expenditures made by the consultant shall be reported by the committee in Part 2 of Schedule G and shall include the date of the expenditure, the purpose of the expenditure and the amount of the expenditure. The description of the purpose of the expenditure shall be consistent with the provisions of subrule 4.15(3).

For purposes of this rule, "contract" means an oral or written agreement between two parties for the supply or delivery of specific services in the course of the campaign. "Performance" means the execution or fulfillment of the contractual agreement. "Nature of performance" means a clear description of the specific services received or benefit derived as the result of a contract with a consultant. "Estimate of performance" means a clear description of the services the committee reasonably expects to receive or the benefit the committee reasonably expects to derive during the period of the contract.

This rule is intended to implement Iowa Code sections 68A.102(9) as amended by 2005 Iowa Acts, House File 312, section 3, and 68A.402A.

351—4.20(68A,68B) Schedule H - Campaign Property.

4.20(1) *Ongoing inventory.* Equipment, supplies, or other materials purchased with campaign funds or received in kind are campaign property. Campaign property, other than consumable campaign property, with a value of \$500 or more when acquired by the committee shall be listed on the inventory section of the schedule. The property shall be listed on each report until it is disposed of by the committee or its residual value falls below \$100 and the property is listed once as having a residual value of less than \$100. "Consumable campaign property" means stationery, yard signs, and other campaign materials that have been permanently imprinted to be specific to a candidate or election. For property purchased by the committee, the date purchased shall be the earlier of the date the committee

attained physical possession of the property or the date the committee issued payment for the property. For in-kind contributions, the date received shall be the date on which the committee attained physical possession of the property. The committee shall provide the complete date (month/day/year). The schedules shall include the purchase price of property purchased by the committee and the actual or estimated fair market value of property received as an in-kind contribution, as well as the actual or estimated current fair market value of the property at the end of the current reporting period.

4.20(2) Sales or transfers of campaign property. The schedule shall include information regarding the sale or transfer of campaign property, other than consumable campaign property, which occurred during the current reporting period. The information shall include the complete date of the transaction (month/day/year), the name and address of the purchaser or donee, and a description of the property. If the property is sold, the information shall include the sales price received; if the property is donated, the information shall include the fair market value of the property at the time of the transfer.

This rule is intended to implement Iowa Code Supplement sections 68A.304 and 68A.402.

351—4.21(68A) Reconciled bank statement required with January report and final report.

4.21(1) A committee that participates in an election at the state level and that is required by Iowa Code Supplement section 68A.402 to file a disclosure report on or before January 19 of each year shall attach to or submit with that disclosure report a copy of the committee's bank statement that includes activity through December 31 of the year reported.

4.21(2) A committee that participates in an election at the county, city, school, or other political subdivision level and that is required by Iowa Code Supplement section 68A.402 to file a disclosure report on or before January 19 of each year is not required to attach or submit a copy of the committee's bank statement unless requested to do so by the board. If such a committee is requested to file the bank statement, the committee shall comply with the requirements of rule 351—4.21(68A).

4.21(3) If the bank statement cycle is such that the committee has not received the statement including activity through December 31 by the date for filing the January report, the committee shall separately file or submit the bank statement within ten days after receipt of the statement by the committee.

4.21(4) The committee shall include a reconciliation to justify outstanding checks and other discrepancies between the ending balance on the bank statement and the ending balance on the disclosure report.

4.21(5) A committee that files a final disclosure report shall comply with the requirements of subrule 4.55(5) concerning the filing of a final bank statement.

4.21(6) A committee seeking a waiver from the requirements of this rule may do so in accordance with 351—Chapter 15.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.22(68A,68B) Verification of reports; incomplete reports.

4.22(1) The board staff will review and desk audit each disclosure report. The board may contact other parties to verify the accuracy and completeness of the reports. The board may contact a representative of the committee and may contact other parties to determine the authenticity of information provided about filed reports.

4.22(2) If, upon review, board staff determine that a committee's report is incomplete because required information has been omitted or has been incorrectly reported, the staff shall communicate the deficiencies to the committee. A failure to satisfactorily respond to or to remedy the error or omission may be grounds for a violation of Iowa Code Supplement section 68A.402 as a failure to file a report which conforms to the requirements of that provision.

This rule is intended to implement Iowa Code Supplement section 68A.402 and Iowa Code section 68B.32A.

351—4.23(68A,68B) Amendment—statements, disclosure reports and notices. A committee may amend a previously filed statement of organization, disclosure report or notice of dissolution. To amend

a previously filed statement, report or notice, the committee shall file an amended document on the approved form and shall designate on the form in the space provided, if applicable, that the document being filed is an amendment to a previously filed statement, report or notice. The term “amended document” as used in this rule shall mean a document on forms issued by the board which includes only the information which is being added, deleted or changed from a previously filed statement of organization or notice of dissolution.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.24(68A) Reporting of state party building fund transactions. Pursuant to Federal Election Commission Advisory Opinion 2004-28, the board will permit a state statutory political committee (state party committee) to receive contributions from corporations, insurance companies, and financial institutions when those contributions are placed in the state party building fund account, the contributions are used to pay for costs associated with the building, and all transactions involving the fund are disclosed pursuant to this rule.

A state party committee filing a state party building fund report under this rule shall use either the report form prescribed by the board or a computer-generated report so long as the report includes the information required under subrule 4.24(2).

4.24(1) Period covered. A state party building fund report shall cover the time period from January 1 through December 31 of the previous year.

4.24(2) Information to be disclosed. The following information shall be disclosed on a state party building fund report:

- a. The name and address of the state party committee.
- b. The name and address of each person who makes a contribution in excess of \$200, or contributions in the aggregate that exceed \$200 during the period covered, to the state party building fund. If no contributions were received for the fund, the report shall disclose \$0.00 as contributions received.
- c. The date and the amount of the contribution. If aggregate contributions from one person are received that exceed \$200, the amount to be disclosed shall be the total amount received from that person for the period covered and the date to be disclosed shall be the date of the last contribution.
- d. The total amount of all contributions of \$200 or less received during the period covered. This total amount shall be disclosed as being received from “unitemized” with the date of the contribution being the last day of the reporting period.
- e. The name and mailing address of each person to whom an expenditure that exceeds \$200 is made, or expenditures in the aggregate that exceed \$200 during the period covered, from the state party building fund. If no expenditures were made from the fund, the report shall disclose \$0.00 as expenditures made.
- f. The date and the amount of the expenditure. If aggregate expenditures that exceed \$200 are made to one person, the amount to be disclosed shall be the total amount made to that person for the period covered and the date to be disclosed shall be the date of the last expenditure.
- g. The total amount of all expenditures of \$200 or less made during the period covered. This total amount shall be disclosed as being expended to “unitemized” with the date of the expenditure being the last day of the reporting period.
- h. The signature and date of the individual filing the state party building fund report.

4.24(3) Place of filing. A state party building fund report shall be filed with the board at 510 E. 12th Street, Suite 1A, Des Moines, Iowa 50319, or by fax at (515)281-3701.

4.24(4) Time of filing. A state party building fund report shall be filed on or before January 31 of each year. If mailed, the report must bear a United States Postal Service postmark dated on or before the due date. A faxed report must be submitted on or before 11:59 p.m. on the due date. If January 31 falls on a Saturday, Sunday, or holiday on which the board office is closed, the due date shall be extended to the next working day when the board office is open.

4.24(5) Failure to file. If the board determines that a state party committee has failed to timely file a state party building fund report, the state party committee is subject to the possible imposition of board sanctions.

This rule is intended to implement Iowa Code sections 68A.402A(1) “k” and 68A.503.

351—4.25(68A,68B) Legitimate expenditures of campaign funds.

4.25(1) Expenses which may be paid from campaign funds for campaign purposes include, but are not limited to, the following items so long as the items promote or enhance the candidacy of the candidate:

- a. Electronic media advertising, such as radio, cable television and commercial television.
- b. Published advertising, such as newspaper, magazine, newsletter and shopper advertising.
- c. Printed promotional materials, such as brochures, leaflets, flyers, invitations, stationery, envelopes, reply cards, return envelopes, campaign business cards, direct mailings, postcards and “cowboy” political cards.
- d. Political signs, such as yard signs, car signs, portable outdoor advertising, stationary outdoor advertising and billboards.
- e. Political advertising specialty items, such as campaign buttons, campaign stickers, bumper stickers, campaign pins, pencils, pens, matchbooks, balloons, scratch pads, calendars, magnets, key chains, and articles of clothing that are political advertising.
- f. Travel and lodging expenses of the campaign workers for campaign purposes and political party activities. Travel and lodging expenses for a candidate to attend a national political party convention are also permitted.
- g. Contributions to political party committees.
- h. The purchase of tickets to a meal for the candidate and one guest so long as the attendance at the meal by the candidate and guest is for the sole purpose of enhancing the candidacy of any person.
- i. General campaign expenditures, such as printing, copy machine charges, office supplies, campaign photographs, gambling permits, fund-raiser prizes, postage stamps, postage meter costs, bulk mail permits, telephone installation and service, facsimile charges, and computer services. However, the purchase or rental of formal wear to attend a political event is not a permissible general campaign expenditure.
- j. Purchase or lease of campaign equipment, such as copy machines, telephones, facsimile machines, computer hardware, software and printers.
- k. Purchase or lease of campaign office space, parking lots or storage space and the payment for campaign office utilities and maintenance.
- l. Payment of salaries, fringe benefits, bonuses, and payroll taxes of paid campaign staff. As provided in Iowa Code section 68A.302(2) as amended by 2009 Iowa Acts, Senate File 50, section 1, family members who perform actual work or services for a campaign and are not the candidate, candidate’s spouse, or candidate’s dependent children may be compensated for such work or services.
- m. Payment for check printing and financial institution banking service charges.
- n. Lease or rental of a campaign vehicle, provided that a detailed trip log which provides dates, miles driven, destination and purpose is maintained, and that noncampaign miles are reimbursed to the committee at an amount not to exceed the current rate of reimbursement allowed under the standard mileage rate for computations of business expenses pursuant to the Internal Revenue Code. However, the purchase of a campaign vehicle is prohibited.
- o. Reimbursement to candidates and campaign workers for mileage driven for campaign purposes in a personal vehicle, provided that a detailed trip log which provides dates, miles driven, destination and purpose is maintained, and that reimbursement is paid at an amount not to exceed the current rate of reimbursement allowed under the standard mileage rate for computations of business expenses pursuant to the Internal Revenue Code.
- p. Payment for food expenses and supplies for campaign-related activities, such as the purchase of food, beverages and table service for fund-raising events or campaign volunteers. However, except as provided in paragraph “h,” the purchase of tickets for meals or fund-raising events for other candidates is prohibited, and the purchase of groceries for the candidate or candidate’s family is also prohibited.

Payment for meals for the candidate (other than those involving tickets for fund-raiser events as addressed in paragraph “h”) is permitted as an allowable expenditure for campaign purposes if the meal was associated with campaign-related activities.

- q.* Payment of civil penalties and hearing costs assessed by the board.
 - r.* Payment for the services of attorneys, accountants, consultants or other professional persons when those services relate to campaign activities.
 - s.* Subscriptions to newspapers and periodicals that circulate within the area represented by the office that a candidate is seeking or holds, that contain information of a general nature about the state of Iowa, or that contain information useful to all candidates such as The Wall Street Journal and Roll Call. Candidates who are unsure whether a subscription is permissible shall seek guidance from the board prior to paying for the subscription with campaign funds.
 - t.* Membership in service organizations including a local chamber of commerce that the candidate joins solely for the purpose of enhancing the candidate’s candidacy.
 - u.* Repayment of campaign loans made to the committee. As provided in Iowa Code section 68A.302(2) as amended by 2009 Iowa Acts, Senate File 50, section 1, candidates who make loans to their own committees shall not charge interest on the loans.
 - v.* Purchase of reports of other candidates and political committees so long as the reports’ contents are not used for solicitation or commercial purposes.
 - w.* Donations to charitable organizations unless the candidate or the candidate’s spouse, child, stepchild, brother, brother-in-law, stepbrother, sister, sister-in-law, stepsister, parent, parent-in-law, or stepparent is employed by the charitable organization and will receive a direct financial benefit from a donation.
 - x.* Contributions to federal, state, county and city political party committees.
 - y.* Refunds to contributors when a contribution has been accepted in error, or when a committee chooses to dispose of leftover funds by refunding them in prorated shares to the original contributors.
 - z.* Payment for items with a purchase price not to exceed \$250 per person that are presented to committee workers in recognition of services to the committee.
 - aa.* Expenses incurred with respect to an election recount as provided in Iowa Code section 50.48.
 - bb.* The sharing of information in any format such as computer databases containing yard sign locations or lists of registered voters with another candidate’s committee.
- 4.25(2)** Expenses which may be paid from campaign funds for educational and other expenses associated with the duties of office include, but are not limited to, the following items:
- a.* Purchase or lease of office supplies and equipment, such as paper, copy machines, telephones, facsimile machines, computer hardware, software and printers.
 - b.* Travel, lodging and registration expenses associated with attendance at an educational conference of a state, national, or regional organization whose memberships and officers are primarily composed of state or local government officials or employees. However, meal expenses are not allowable as expenses associated with the duties of office under any circumstances.
 - c.* Meals and other expenses incurred in connection with attending a local meeting to which the officeholder is invited and attends due to the officeholder’s official position as an elected official.
 - d.* Purchases of small, incidental items such as pencils, pens, rulers and bookmarks provided to members of the public touring the offices of the state or a political subdivision. However, such items distributed on public property shall not expressly advocate the election or defeat of a candidate or the adoption or defeat of a ballot issue as prohibited in Iowa Code Supplement section 68A.505. For example, a bookmark bearing the state seal could be distributed on public property, while a bookmark that identified the donor as a candidate for office could not be distributed on public property.
 - e.* Gifts purchased for foreign dignitaries when the officeholder is part of an official trip out of the country such as a trade mission or exchange program.
 - f.* Printing of additional stationery and supplies above the standard allotment of the state or political subdivision.

4.25(3) Expenses which may be paid from campaign funds for constituency services include, but are not limited to, the following items:

- a. Mailings and newsletters sent to constituents.
- b. Polls and surveys conducted to determine constituent opinions.
- c. Travel expenses incurred in communicating with members of an elected official's constituency, provided that a detailed trip log which provides dates, miles driven, destination and purpose is maintained, and that reimbursement is paid at an amount not to exceed the current rate of reimbursement allowed under the standard mileage rate for computations of business expenses pursuant to the Internal Revenue Code. However, meal expenses are not allowable as expenses associated with constituency services under any circumstances.
- d. Holiday and other greeting cards sent to constituents.

This rule is intended to implement Iowa Code Supplement sections 68A.301, 68A.302, and 68A.303. [ARC 7647B, IAB 3/25/09, effective 4/29/09; ARC 7801B, IAB 6/3/09, effective 7/8/09]

351—4.26(68A) Transfers between candidates.

4.26(1) *Transfer of assets between different candidates.* A candidate's committee may transfer an asset to a candidate's committee established by a different candidate so long as the recipient committee pays the transferring committee the fair market value of the asset and the transaction is properly disclosed on each committee's disclosure report.

4.26(2) *Transfer of assets for same candidate.* A candidate's committee may transfer funds, assets, loans, and debts to a committee established for a different office when the same candidate established both committees.

This rule is intended to implement Iowa Code Supplement section 68A.303.

351—4.27(68A) Filing of independent expenditure statement. Pursuant to Iowa Code section 68A.404 as amended by 2009 Iowa Acts, Senate File 49, section 5, any person except a candidate, a registered committee, a federal committee, or an out-of-state committee that makes one or more independent expenditures in excess of \$100 in the aggregate shall file an independent expenditure statement.

4.27(1) *Independent expenditure defined.* "Independent expenditure" means an expenditure for a communication that expressly advocates the nomination, election, or defeat of a candidate or that expressly advocates the passage or defeat of a ballot issue when the expenditure is made without the prior approval of or coordination with a candidate, candidate's committee, or a ballot issue committee. "Independent expenditure" also means "independent expenditure" as defined in subrule 4.53(3).

4.27(2) *Independent expenditure statement.* The following information shall be disclosed on the independent expenditure statement:

- a. The name, mailing address, and telephone number of the person that files the statement, including the name, mailing address, and telephone number of a contact person, if applicable.
- b. A description of the position that is advocated by the person that files the statement such as whether the communication was for a particular candidate or was against a particular candidate.
- c. The name and address of the committee that benefits from the expenditure.
- d. The dates on which the expenditure or expenditures took place.
- e. A description of the nature of the action taken that resulted in the expenditure or expenditures such as a newspaper advertisement, direct mailing, or brochure.
- f. The actual cost or fair market value of the expenditure or expenditures.

4.27(3) *Place of filing.* An independent expenditure statement shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, or by fax at (515)281-4073. The board shall immediately make the independent expenditure statement available for public viewing via the board's Web site at www.iowa.gov/ethics.

4.27(4) *Time of filing.* An independent expenditure statement shall be filed within 48 hours of the making of an independent expenditure exceeding \$100 or independent expenditures exceeding \$100 in the aggregate. An independent expenditure is deemed made at the time that the cost is incurred.

4.27(5) *Failure to file.* A person that fails to timely file an independent expenditure statement shall be subject to the imposition of civil penalties pursuant to 351—subrule 4.59(7).

4.27(6) Attribution statement applicable. Any person that makes an independent expenditure in any amount shall comply with the appropriate “paid for by” attribution statement pursuant to rule 351—4.38(68A,68B).

4.27(7) Other filings not required. A person that properly files an independent expenditure statement shall not be required to file a statement of organization registering a committee or file public disclosure reports.

4.27(8) Campaign committees. A committee that makes an independent expenditure shall disclose the transaction on the committee’s appropriate disclosure report and shall not file an independent expenditure statement.

This rule is intended to implement Iowa Code section 68A.404 as amended by 2008 Iowa Acts, House File 2700, sections 116 and 117.
[ARC 7800B, IAB 6/3/09, effective 7/8/09]

351—4.28(68A) Prohibition on contributions and independent expenditures by foreign nationals. As provided in Federal Election Commission regulation 11 CFR 110.20, a foreign national shall not, directly or indirectly, make a contribution or expenditure of money or other thing of value, or specifically promise to make a contribution, in connection with a state or local campaign or election in Iowa. A foreign national shall not, directly or indirectly, make a contribution to a campaign committee organized under Iowa Code Supplement chapter 68A. Foreign nationals are also prohibited from making independent expenditures in relation to any state or local campaign or election in Iowa.

4.28(1) Foreign national defined. “Foreign national” means a person who is not a citizen of the United States and who is not lawfully admitted for permanent residence. “Foreign national” also includes a “foreign principal,” such as a government of a foreign country or a foreign political party, partnership, association, corporation, organization, or other combination of persons that has its primary place of business in or is organized under the laws of a foreign country. “Foreign national” shall not include any person who is a citizen of the United States or who is a national of the United States.

4.28(2) Acceptance of contributions and independent expenditures from foreign nationals. No person shall knowingly accept or receive any contribution from a foreign national with regard to such person’s election-related activities.

4.28(3) Participation by foreign nationals in decisions involving election-related activity. A foreign national shall not, directly or indirectly, participate in the decision-making process of any person, including a corporation, labor organization, political committee, or political organization, with regard to such person’s election-related activities. Decisions including election-related activities include decisions involving the making of contributions, donations, or expenditures in connection with elections for state or local office or decisions involving the administration of a political committee.

This rule is intended to implement Iowa Code Supplement chapter 68A.

351—4.29(68A,68B) Contributions by minors. Persons under 18 years of age may make contributions to a candidate or political committee if all of the following conditions exist:

1. The decision to contribute is made knowingly and voluntarily by the minor;
2. The funds, goods, or services contributed are owned or controlled exclusively by the minor, such as income earned by the minor, the proceeds of a trust for which the minor is the beneficiary, or a savings account opened and maintained exclusively in the minor’s name; and
3. The contribution is not made from the proceeds of a gift, the purpose of which was to provide funds to be contributed, or is not in any other way controlled by another person.

This rule is intended to implement Iowa Code Supplement section 68A.404.

351—4.30(68A,68B) Funds from unknown source prohibited; subsequent identification of source; notice to contributors.

4.30(1) Anonymous contributions in excess of \$10 prohibited. No person shall make a contribution in excess of \$10 to a committee without providing the person’s name and address to the committee. The

committee shall not maintain in any campaign account funds in excess of \$10 that cannot be accounted for and reconciled with the committee's disclosure reports.

4.30(2) *Escheat to the state.* Any contribution in excess of \$10 from an unknown source or campaign funds in excess of \$10 that cannot be accounted for and reconciled shall escheat to the state of Iowa as required by Iowa Code section 68A.501 as amended by 2007 Iowa Acts, Senate File 39, section 8. A committee required to escheat shall escheat such funds by depositing the funds into the committee's campaign account and issuing a committee check to the general fund in the same amount. The committee check shall be sent to the board office at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, for transmittal to the office of treasurer of state.

4.30(3) *Subsequent identification of source.* A committee discovering the source of any funds that have been escheated to the state may make an application to the board for a return of the funds if the following requirements are met:

- a. The committee has not dissolved;
- b. Documentation of the name and address of the source is provided;
- c. The amount requested to be returned is in excess of \$100; and
- d. The application is made within 90 days of the date of the deposit in the general fund of the state of Iowa.

4.30(4) *Notice at fund-raising event.* Pursuant to Iowa Code Supplement section 68A.501, a person requested to make a contribution at a fund-raising event shall be advised that it is illegal to make a contribution in excess of \$10 unless the person making the contribution also provides the person's name and address. Notice of the requirement to provide a person's name and address for a contribution in excess of \$10 may be made orally or in a written statement that is displayed at the fund-raising event.

This rule is intended to implement Iowa Code section 68A.501.

351—4.31(68A) Information required for a trust to avoid a contribution in the name of another person. A contribution to a committee by a trustee solely in the name of the trust constitutes a contribution in the name of another person as prohibited in Iowa Code Supplement section 68A.502 unless the recipient committee publicly discloses the contribution as provided in this rule.

4.31(1) *Living or revocable trust.* If the contribution involves a trust identified as a revocable trust or a living trust that does not file a separate trust tax return and whose federal tax ID number is the same as the social security number of the grantor who creates the trust and who is also a trustee, the contribution shall be reported by the recipient committee as being made by the "(name) revocable (or living) trust."

4.31(2) *Other trusts.* For a contribution involving a trust that does not qualify under subrule 4.31(1), the recipient committee shall identify the trust, the trustee, and the trustor.

4.31(3) *Registering a committee.* A trust, except for a living or revocable trust, that raises or spends more than \$750 for campaign activities shall register a political committee (PAC) and shall file disclosure reports. A trust, except for a living or revocable trust, that makes a one-time contribution in excess of \$750 may file Form DR-OTC in lieu of filing a statement of organization and filing disclosure reports.

This rule is intended to implement Iowa Code Supplement sections 68A.402(6) and 68A.502.

351—4.32(68A) Contributions from political committees not organized in Iowa. Iowa committees may receive contributions from committees outside Iowa, and committees outside Iowa may contribute to Iowa committees provided the out-of-state committee complies with either subrule 4.32(1) or subrule 4.32(2). For purposes of this rule, "out-of-state committee" means a committee that is registered with the campaign enforcement agency of another state or is registered with the Federal Election Commission.

4.32(1) *Regular filings.* Out-of-state committees may choose to comply with the regular disclosure filing requirements in Iowa Code Supplement sections 68A.201 and 68A.402 by filing a statement of organization and periodic disclosure reports.

4.32(2) *Verified statement of registration.* In lieu of filing a statement of organization and regular disclosure reports as required by Iowa Code chapter 68A, the out-of-state committee shall file with the board a verified statement registration form (VSR) for each contribution in excess of \$50. The VSR shall contain the following information:

- a. The complete name, address and telephone number of the out-of-state committee;
- b. The state or federal agency with which the out-of-state committee is registered;
- c. All parent entities or other affiliates or sponsors of the out-of-state committee;
- d. The purpose of the out-of-state committee;
- e. The name, address and telephone number of an Iowa resident authorized to receive service on behalf of the out-of-state committee;
- f. The name and address of the Iowa recipient committee;
- g. The date and amount of the contribution, including description if the contribution is in-kind; and
- h. An attested statement that the jurisdiction with which the out-of-state committee is registered has reporting requirements substantially similar to those of Iowa Code chapter 68A. The statement shall include confirmation that the contribution is made from an account that does not accept contributions prohibited by Iowa Code section 68A.503 unless the contribution from the out-of-state committee is made to an Iowa ballot issue committee.

4.32(3) Signature. The VSR shall be signed by the individual filing the VSR on behalf of the out-of-state committee. A VSR that is filed electronically using the board's Web site is deemed signed when filed.

4.32(4) Where filed. Every VSR filed for a contribution in excess of \$50 shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, electronically using the board's Web site at www.iowa.gov/ethics, as an E-mail attachment, or by fax at (515)281-4073.

4.32(5) When filed. The VSR shall be filed with the board on or before the fifteenth day after the date of the contribution, or mailed bearing a United States Postal Service postmark dated on or before the fifteenth day after the date of the contribution. For purposes of this subrule, "date of the contribution" means the day, month, and year the contribution check is dated. If the board deems it necessary, a copy of any contribution check may be required to be filed with the board. When a copy of a check is required to be filed with the board, the copy shall be filed within ten days after notice by the board.

4.32(6) Enhanced filing. An out-of-state committee determining that the jurisdiction under which the committee is registered does not have reporting requirements substantially similar to those of Iowa Code Supplement chapter 68A may choose to comply by enhancing the committee's filing in the other jurisdiction. The enhanced filing shall meet the reporting requirements of Iowa Code Supplement chapter 68A for the reporting period during which contributions to Iowa committees are made. The report shall cover a period of at least one month. An out-of-state committee choosing this option shall comply with the VSR procedures in subrule 4.32(2) and attach a signed statement that the report has been enhanced to satisfy the Iowa reporting requirements.

This rule is intended to implement Iowa Code section 68A.201(5).

351—4.33(68A,68B) Reporting of earmarked contributions. A political committee is permitted to receive contributions from its contributors which are earmarked to be donated to a specific candidate's committee or another political committee. A political committee receiving and transmitting earmarked contributions is required to list on its disclosure report the name of the contributor and the name of the candidate or committee for which the contribution was earmarked. The political committee is further required to inform the treasurer of the recipient committee in writing of the name of the individual contributor, as well as the name of the committee which has collected the contribution. The committee receiving the earmarked contribution is required to disclose on its report both the name of the individual contributor and the sponsoring committee.

This rule is intended to implement Iowa Code Supplement section 68A.402.

351—4.34(68A) Copies of reports filed by 527 Committees. Iowa Code section 68A.401A requires the board to adopt a procedure for 527 Committees that file reports with the Internal Revenue Service and engage in issue advocacy in Iowa to file copies of those reports with the board. If a 527 Committee notifies the board that it is filing reports with the Internal Revenue Service, the 527 Committee will be deemed in compliance with Iowa Code section 68A.401A. The board will then establish on its Web site

a link to the reports filed with the Internal Revenue Service, or the board will otherwise post on its Web site the reports filed with the Internal Revenue Service.

This rule is intended to implement Iowa Code section 68A.401A.

351—4.35(68A) Permanent organizations forming temporary political committees; one-time contributor filing Form DR-OTC. Pursuant to Iowa Code section 68A.402(9), a permanent organization temporarily engaging in activity that exceeds the \$750 financial filing threshold described in rule 351—4.1(68A,68B) is required to organize and register a political committee (PAC), file disclosure reports, and, upon completion of activity, file a notice of dissolution. A permanent organization that is temporarily a political committee shall comply with all of the campaign laws in Iowa Code chapter 68A and this chapter. A permanent organization that makes loans to a candidate or committee or that is owed debts from a candidate or committee is not deemed to be engaging in political activity requiring registration.

4.35(1) Form DR-OTC. A permanent organization that makes a one-time contribution in excess of \$750 to a committee may, in lieu of filing a statement of organization, disclosure reports, and a notice of dissolution, file Form DR-OTC. The following information shall be disclosed on Form DR-OTC:

a. The name and address of the organization making the contribution.
b. The name and address of a contact person for the organization making the contribution.
c. The name and address of the campaign committee receiving the contribution. If the contribution is to a candidate or a candidate's committee, the source of the original funds used to make the contribution shall be disclosed.

d. The date and amount of the contribution. If the contribution is an in-kind contribution, a description of the provided goods or services must be included.

e. The date of election and the county in which the recipient committee is located if the committee is a county or local committee.

f. The date and signature of the person filing Form DR-OTC. A Form DR-OTC that is filed electronically using the board's Web site is deemed signed when filed.

A permanent organization that makes more than one contribution is not eligible to file Form DR-OTC and is required to file a statement of organization, file disclosure reports, and file a notice of dissolution.

4.35(2) Place of filing. Form DR-OTC shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, filed by fax at (515)281-4073, or filed electronically using the board's Web site at www.iowa.gov/ethics.

4.35(3) Time of filing. Form DR-OTC shall be filed with the board within ten days after the one-time contribution in excess of \$750 is made. The form must be physically received by the board or, if mailed, must bear a United States Postal Service postmark dated on or before the report due date. A faxed or electronically filed Form DR-OTC must be submitted on or before 11:59 p.m. of the tenth day after the organization of the committee is required. If the tenth day falls on a Saturday, Sunday, or holiday on which the board office is closed, the filing deadline is extended to the next working day when the board office is open.

4.35(4) Failure to register. If the board discovers that a permanent organization has become subject to the provisions of Iowa Code Supplement chapter 68A but did not timely file a statement of organization or file Form DR-OTC, as applicable, the permanent organization is subject to the possible imposition of board sanctions.

4.35(5) Partial refund of contribution. A committee that receives a contribution from a permanent organization that causes the organization to become subject to the provisions of Iowa Code Supplement chapter 68A may refund all or part of a contribution to the organization so as to reduce the contribution to \$750 or less and remove the organization's filing obligations.

This rule is intended to implement Iowa Code sections 68A.102(18) and 68A.402.

351—4.36(68A) Cash transactions. All disbursements, including all expenditures and any other withdrawals from committee funds, shall be by check, debit card, or credit card. Cash withdrawals and "petty cash" accounts are not permitted. If a committee fundraising activity necessitates a cash drawer

for making change or other cash transactions, the committee may issue a check payable to the committee treasurer or the candidate, in the case of a candidate's committee, or payable to the committee treasurer or the committee chairperson, in the case of a political committee. The purpose of the expenditure shall be reported on Schedule B as "cash advance for (describe activity, e.g., concession stand cash drawer)." Upon completion of the fundraising activity, the committee shall redeposit the same amount as that which was advanced into the committee account. The redeposit shall be reported as a reverse entry on Schedule B as a "redeposit of cash advance for (describe activity)." The proceeds of the fundraising activity (excluding the cash advance) shall be reported on Schedule A - Contributions Received.

This rule is intended to implement Iowa Code sections 68A.203 as amended by 2005 Iowa Acts, House File 312, section 5, and 68A.402A.

351—4.37(68A,68B) Record keeping.

4.37(1) *Copies of reports.* A committee shall preserve a copy of every report it files for at least three years following the filing of the report.

4.37(2) *Supporting documentation.* The documentation which supports a committee's disclosure report shall be preserved by the committee for at least five years after the due date of the report that covers the activity documented in the records; however, a committee is not required to preserve these records for more than three years from the certified date of dissolution of the committee. At a minimum, the supporting documentation shall consist of all of the following:

a. A ledger or similar record-keeping device which details all contributions received by the committee. This record shall include the name and address of each person making a contribution in excess of \$10, with the date and amount of the contribution. In lieu of or in addition to a ledger, the committee may record contributions received through a receipt book or other method of individually documenting the contributions, such as by making and keeping copies of the contribution checks.

b. The check register for the committee's account(s).

c. Bank statements for the committee's account(s).

d. Copies of canceled or duplicate checks for committee expenditures, if available.

e. Copies of bills or receipts for committee expenditures.

f. For committees which pay reimbursement for committee-related mileage, copies of vehicle mileage logs, including travel dates, distance driven, and travel purpose (description of event or activity). For a candidate's committee which leases a vehicle, the mileage log shall detail all mileage driven on the vehicle, including non-committee-related mileage.

This rule is intended to implement Iowa Code Supplement sections 68A.203, 68A.302, 68A.402 and 68A.403 and Iowa Code section 68B.32A.

DIVISION III
POLITICAL MATERIAL—ATTRIBUTION STATEMENTS

351—4.38(68A) Political attribution statement—contents. Published material that expressly advocates the election or defeat of a candidate or that expressly advocates the passage or defeat of a ballot issue shall contain a statement identifying the person paying for the published material. This statement is referred to as the "attribution statement." The term "published material" means any newspaper, magazine, shopper, outdoor advertising facility, poster, direct mailing, brochure, Internet Web site, campaign sign, or any other form of printed general public political advertising.

4.38(1) *Registered committee.* If the person paying for the published material is a committee that has filed a statement of organization, the words "paid for by" and the name of the committee shall appear on the material.

4.38(2) *Individual, married couple, or unregistered candidate's committee.* If the person paying for the published material is an individual, the words "paid for by" and the name and address of the individual shall appear on the material. Published material that is jointly paid for by a married couple shall include the words "paid for by" and the name and address of one member of the married couple. For purposes of

this subrule, “individual” includes a candidate who has not filed a statement of organization to register a committee.

4.38(3) *Multiple individuals.* If more than one individual paid for the published material, the words “paid for by”, the names of the individuals, and either the addresses of the individuals or a statement that the addresses of the individuals are on file with the Iowa ethics and campaign disclosure board shall appear on the material. The addresses shall be provided to the board and made available for public inspection.

4.38(4) *Organization or unregistered political committee.* If the person paying for the published material is an organization, the words “paid for by”, the name and address of the organization, and the name of one officer of the organization shall appear on the material. For purposes of this subrule, “organization” includes an organization advocating the passage or defeat of a ballot issue but that has not filed a statement of organization to register a political committee.

4.38(5) *Pooled efforts.* If the published material is paid for by more than one person, the words “paid for by” and the identification of the persons as set out in this rule shall appear on the material.

This rule is intended to implement Iowa Code Supplement section 68A.405 as amended by 2004 Iowa Acts, House File 2319, section 4.

351—4.39(68A) Specific items exempted from or subject to attribution statement requirement; multiple pages. Iowa Code Supplement section 68A.405 requires the placement of a “paid for by” attribution statement on political advertising and political material, with certain exceptions.

4.39(1) *Items exempted from requirement.* The requirement to place a “paid for by” attribution statement does not apply to the following:

- a. Editorials or news articles of a newspaper or magazine that are not political advertisements.
- b. Small items upon which the inclusion of the attribution statement would be impracticable, such as yard signs, bumper stickers, pins, buttons, pens, pencils, emery boards, matchbooks and, except as set out in subrule 4.39(2), items that are smaller than 2 inches by 4 inches.
- c. T-shirts, caps, and other articles of clothing.
- d. Means of communication such as television and radio that are subject to federal regulations regarding an attribution requirement.
- e. Political advertising or political material placed by an individual who acts independently and spends \$100 or less of the individual’s own money to expressly advocate the passage or defeat of a ballot issue.

For purposes of this subrule, “yard sign” means a political sign with a total dimension of 32 square feet or less, regardless of whether both sides of the sign are used, that has been placed or posted on real property.

4.39(2) *Items subject to requirement.* The requirement to place a “paid for by” attribution statement applies to the following:

- a. Advertising such as yard signs larger than 32 square feet, billboards, posters, portable sign carriers, and signs affixed or painted to the side or top of a building or vehicle.
- b. Advertisements in a newspaper, magazine, shopper, or other periodical regardless of the size of the advertisement.
- c. Direct mailings, flyers, brochures, postcards, or any other form of printed general public advertising that is larger than 2 inches by 4 inches.
- d. Campaign Web sites.

4.39(3) *Multiple pages.* If the political advertising or political material consists of more than one page, the “paid for by” attribution statement need only appear on one page of the advertising or material. For a campaign Web site, the attribution statement need only appear on the home page of the site.

This rule is intended to implement Iowa Code Supplement section 68A.405.

351—4.40(68A,68B) Newspaper or magazine. For the purposes of these rules and Iowa Code Supplement section 68A.405, “newspaper or magazine” means a regularly scheduled publication

of news, articles of opinion, and features available to the general public which does not require membership in or employment by a specific organization.

This rule is intended to implement Iowa Code Supplement section 68A.405.

351—4.41(68A,68B) Apparent violations; remedial action.

4.41(1) *Administrative resolution.* In an effort to informally resolve apparent violations of the requirement to place a “paid for by” attribution statement, the board may order administrative resolution of the matter. The board may direct the person responsible for placing the original published political material that did not include the attribution statement to place a correction notice in a local newspaper that reaches the same or substantially the same portion of the public that received the original published political material. A person may also resolve a violation of the “paid for by” attribution statement by resending corrected published political material to the same portion of the public that received the original published political material and by filing a copy of the corrected material with the board.

4.41(2) *Form of correction notice.* The correction notice shall be in substantially the following form: “On (date) (describe the type of published political material) was distributed that did not state who paid for it. The (describe the type of published political material) was paid for by (insert name).”

4.41(3) *Board notice.* The board shall notify the person who paid for the original published political material of the requirements of this rule.

4.41(4) *Refusal to place correction notice.* The board may initiate a contested case proceeding and impose discipline against any person who refuses to place a correction notice under this rule.

This rule is intended to implement Iowa Code section 68A.405 and Iowa Code Supplement section 68B.32A(8) as amended by 2006 Iowa Acts, House File 2512, section 3.

351—4.42(56,68B) Specific items exempted from or subject to attribution statement requirement. Rescinded IAB 2/4/04, effective 3/10/04.

351—4.43(56,68B) Apparent violations; remedial actions. Rescinded IAB 2/4/04, effective 3/10/04.

DIVISION IV
CORPORATE POLITICAL ACTIVITY

351—4.44(68A,68B) Use of corporate property prohibited. It is unlawful for a candidate’s committee or other political committee to use any property of a corporate entity, and it is unlawful for a corporate entity to knowingly permit the use of its property by a candidate’s committee or other political committee. “Corporate entity” as used in these rules means any profit or nonprofit corporation, and includes, but is not limited to, farm corporations, professional corporations (P.C.s), banks, savings and loan institutions, credit unions and insurance companies. For the purpose of these rules, the prohibited use of the property of a corporate entity shall include, but not be limited to, the following:

4.44(1) The physical placement of campaign materials on corporate property except as permitted under Iowa Code sections 68A.406 and 68A.503.

4.44(2) The use of motor vehicles, telephone equipment, long-distance lines, computers, typewriters, office space, duplicating equipment and supplies, stationery, envelopes, labels, postage, postage meters or communication systems of corporate entities.

4.44(3) The use of corporate entity facilities, premises, recreational facilities and housing that are not ordinarily available to the general public.

4.44(4) The furnishing of beverages and other refreshments that cost in excess of \$50 and that are not ordinarily available to the general public.

4.44(5) The contributing of money of the corporate entity.

4.44(6) Any other transaction conducted between a corporation and a candidate’s committee or political committee is presumed to be a corporate contribution unless the candidate’s committee or political committee establishes to the contrary.

This rule is intended to implement Iowa Code Supplement section 68A.503.

351—4.45(68A,68B) Corporate-sponsored political committee. These rules do not prevent a corporate entity from soliciting eligible members to join or contribute to its own corporate-sponsored political committee (PAC), so long as the corporate entity adheres to the provisions of Iowa Code Supplement section 68A.503.

This rule is intended to implement Iowa Code Supplement section 68A.503.

351—4.46(68A) Voter education. These rules do not prevent a corporate entity from providing or publicizing voter registration procedures, election day information, voting procedures or other voter education information, so long as the information provided does not expressly advocate the election or defeat of a clearly identified candidate. Also, these rules do not prevent a candidate's committee from using a corporate computer to generate and file a campaign disclosure report so long as the report does not expressly advocate the election or defeat of a clearly identified candidate.

This rule is intended to implement Iowa Code Supplement section 68A.503.

351—4.47(68A,68B) Permitted activity—reimbursement required. The prohibitions against certain transactions between corporate entities and candidates or committees expressly advocating the election or defeat of candidates contained in Iowa Code Supplement section 68A.503 and in rule 351—4.44(68A,68B) are not construed to prohibit activity that occurs consistent with this rule.

4.47(1) Purchase or rental of office facility. A candidate's committee or any other committee that expressly advocates the election or defeat of a candidate may purchase or rent property belonging to a corporate entity, so long as the purchase or rental is at fair market value. For the purpose of this subrule, "fair market value" means the amount that a member of the general public would expect to pay to purchase or rent a similar property within the community in which the property is located.

4.47(2) Use of corporate facilities to produce or mail materials. Any person who uses the facilities of a corporate entity to produce or mail materials in connection with a candidate election is required to reimburse the corporate entity within a commercially reasonable time for the normal and usual charge for producing or mailing such materials in the commercial market. For example, if it would otherwise cost 10 cents per page to have a brochure copied at a commercial printer, the corporate entity must be reimbursed at 10 cents per page even if the overhead and operating cost is only 5 cents per page. Likewise, the corporate entity must be reimbursed at the first-class mail rate even if the direct cost to the corporate entity is less through the use of its bulk mail permit. This subrule does not affect the ability of a commercial vendor to charge an amount for postage which is less than for first-class mail where the reduced or bulk mail charge is available to all similarly situated customers without respect to the political identity of the customer.

4.47(3) Use or rental of corporate facilities by other persons. Persons other than stockholders, administrative officers or employees of a corporate entity who make any use of corporate facilities, such as using telephones, facsimile machines, typewriters or computers or borrowing office furniture for activity in connection with a candidate election, are required to reimburse the corporate entity within a commercially reasonable time in the amount of the normal and usual rental charge. If one or more telephones of a corporate entity are used as a telephone bank, a rebuttable presumption is established that \$3 per telephone per hour, plus any actual long distance charges, is acceptable as a normal and usual rental charge.

4.47(4) Use of airplanes and other means of transportation.

a. Air travel. A candidate, candidate's agent, or person traveling on behalf of a candidate who uses noncommercial air transportation made available by a corporate entity shall, in advance, reimburse the corporate entity as follows:

(1) Where the destination is served by regularly scheduled commercial service, the coach class airfare (without discounts).

(2) Where the destination is not served by a regularly scheduled commercial service, the usual charter rate.

b. Other transportation. A candidate, candidate's agent, or person traveling on behalf of a candidate who uses other means of transportation made available by a corporate entity shall, within a commercially reasonable time, reimburse the corporate entity at the normal and usual rental charge.

4.47(5) Equal access not required. For the purpose of this rule, it is not necessary that the corporate entity be in the business of selling or renting the property, good or service to the general public; further, it is not necessary that the corporate entity provide access to the same property, good or service to other candidates or committees.

4.47(6) Commercially reasonable time. For the purpose of this rule, a rebuttable presumption is established that reimbursement to the corporate entity within ten business days is acceptable as within a commercially reasonable time.

4.47(7) Loans and debts. A financial institution may make a loan to a candidate or candidate's committee so long as the loan is repaid and all proper public disclosure of the transaction is made pursuant to rule 351—4.18(68A,68B). A candidate or candidate's committee may owe a debt to an insurance company, financial institution, or corporation so long as the debt is repaid and all proper public disclosure of the transaction is made pursuant to rule 351—4.16(68A,68B). The repayment of a loan or debt under this subrule shall be made prior to the dissolution of the committee pursuant to rule 351—4.57(68A,68B).

This rule is intended to implement Iowa Code Supplement section 68A.503.

351—4.48(68A,68B) Use of corporate facilities for individual volunteer activity by stockholders, administrative officers and employees. Rescinded IAB 8/2/06, effective 9/6/06.

351—4.49(68A,68B) Individual property. These rules do not apply to the personal or real property of corporate officers or of individuals employed or associated with a corporate entity and shall not abridge the free-speech rights and privileges of individuals.

This rule is intended to implement Iowa Code Supplement section 68A.503.

351—4.50(68A) Political corporations. The prohibitions in Iowa Code Supplement section 68A.503 on corporations that make expenditures to expressly advocate for or against a clearly identified candidate do not apply to a nonprofit advocacy corporation that has received certification as a political corporation pursuant to this rule.

4.50(1) Applicability. A political corporation may make an independent expenditure as defined in Iowa Code Supplement section 68A.404(1) to expressly advocate for or against a clearly identified candidate. However, a political corporation may not make direct contributions to a candidate's committee, state statutory political committee, county statutory political committee, or any political committee (PAC) that is established to expressly advocate for or against a clearly identified candidate.

4.50(2) Criteria. A corporate entity applying for certification as a political corporation shall meet all of the following criteria:

a. The corporation was organized solely for political purposes and engages in minor business activities that generate minimal income and that are incidental to its political purposes.

b. The corporation is not sponsored by a business corporation and has a policy of accepting only an insignificant and insubstantial amount of income from business corporations.

c. The corporation has no shareholders or others that have claims on its assets or earnings.

4.50(3) Application. A corporate entity seeking certification as a political corporation shall submit a letter affirming that the corporate entity meets all of the criteria set out in subrule 4.50(2). The application letter shall also include all other pertinent details of the corporate entity's activities and shall be signed by a corporate officer.

4.50(4) Board review. The board shall review an application letter from a corporate entity seeking status as a political corporation and shall issue a letter of approval or denial.

4.50(5) Denial or failure to seek certification. It shall be deemed a violation of Iowa Code Supplement section 68A.503 for a corporate entity that is denied certification as a political corporation to make an independent expenditure that expressly advocates for or against a clearly identified candidate.

It shall be deemed a violation of Iowa Code Supplement section 68A.503 for a corporation to make an independent expenditure that expressly advocates for or against a clearly identified candidate without first seeking certification as a political corporation.

4.50(6) Filing. As required by Iowa Code Supplement section 68A.404, a corporate entity granted political corporation status that makes an independent expenditure in excess of \$750 in the aggregate shall file an independent expenditure statement within 48 hours after the making of the expenditure.

4.50(7) Campaign committee incorporation. An Iowa committee organized under Iowa Code Supplement chapter 68A that chooses to incorporate may do so without applying for certification as a political corporation. A committee that chooses to incorporate is not a prohibited contributor under Iowa Code Supplement section 68A.503.

This rule is intended to implement Iowa Code Supplement sections 68A.404 and 68A.503.

351—4.51(68A) Candidate debate—media organization; debate structure; debate funding; contribution reporting inapplicable. Iowa Code Supplement section 68A.503 prohibits corporations from making contributions to state or local candidates in Iowa. This prohibition does not apply to incorporated media organizations that host candidate debates described in this rule.

4.51(1) Media organization defined. “Media organization” means a broadcaster, cable television operator, television programmer, television producer, bona fide newspaper, magazine, or any other periodical publication. The media organization shall not be owned or controlled by a political party, political committee, or candidate.

4.51(2) Debate structure. The structure of the debate shall be left to the discretion of the media organization provided that at least two or more candidates for the particular office are invited to participate. The debate shall not be structured to promote or advance one candidate over another. In choosing which candidates to invite to a debate, the media organization shall use good faith editorial judgment that is reasonable and viewpoint-neutral.

4.51(3) Funding debates. A media organization may use its own funds and may accept funds donated by corporations to defray costs incurred in staging a candidate debate under this rule.

4.51(4) Contribution reporting inapplicable. The costs of a debate under this rule are not a reportable monetary or in-kind contribution under Iowa Code Supplement section 68A.402.

This rule is intended to implement Iowa Code Supplement sections 68A.402 and 68A.503.

351—4.52(68A,68B) Corporate involvement with political committee funds.

4.52(1) Corporate payroll deductions. For purposes of interpretation of Iowa Code Supplement section 68A.503, the administrative functions performed by a corporation (profit or nonprofit corporation including, but not limited to, a bank, savings and loan institution, credit union or insurance company) to make payroll deductions for an employee organization’s political committee and to transmit the deductions in lump sum to the treasurer of the political committee shall not be a prohibited corporate activity so long as the corporate entity is serving only as a conduit for the contributions.

4.52(2) Electronic transfer of deposits. A corporation, financial institution, or insurance company may receive and deposit checks that include both dues and PAC contributions. Contributions for the PAC shall be transferred as soon as possible into the PAC checking account and all disclosure, record-keeping, and record-retention requirements of Iowa Code chapter 68A shall be followed.

4.52(3) Allowable costs of administration. For the purposes of interpreting Iowa Code Supplement section 68A.503, subsection 3, which permits an entity otherwise forbidden from contributing to a candidate or a candidate’s committee for “financing the administration of a committee sponsored by that entity,” the following are considered to be allowable costs of administration:

a. Full or partial compensation for political committee staff, which may include both wages and benefits.

b. Expenses of transportation and travel incurred by political committee staff; however, this does not include expenses of transportation or travel if provided by a political committee or a staff member to a candidate, nor does this include expenses of meals or events held on behalf of a candidate.

c. Printing and office supplies related to routine office administration so long as the printing and supplies are not used to expressly advocate for or against any candidate.

d. Postage and stationery, including that necessary for mailing contributions to specific candidates. Postage and stationery necessary for distributing political material expressly advocating a specific candidate to persons other than the committee membership are not permitted.

e. Expenses of maintaining committee records and preparing financial disclosure reports, including costs associated with services provided by an accountant or other professional.

f. Promotional materials, such as stickers, pens, and coffee cups, so long as the items promote the political committee itself, but not a specific candidate.

An item which is excluded by this subrule from being an allowable cost of administration may still be provided by the committee, so long as that cost is paid for from contributions or other sources of funds other than the parent entity.

This rule is intended to implement Iowa Code Supplement section 68A.503.

DIVISION V
INDEPENDENT EXPENDITURES AND IN-KIND CONTRIBUTIONS

351—4.53(68A,68B) Express advocacy; in-kind contributions; independent expenditures—definitions. For the purposes of Iowa Code Supplement chapter 68A, the following definitions apply.

4.53(1) *Express advocacy.* “Express advocacy” means any communication as defined in Iowa Code Supplement section 68A.102(14). “Express advocacy” includes a communication that uses any word, term, phrase, or symbol that exhorts an individual to vote for or against a clearly identified candidate or for the passage or defeat of a clearly identified ballot issue.

4.53(2) *In-kind contribution.* “In-kind contribution” means the provision of any good or service to a committee without charge or at a charge that is less than the usual and normal charge for such good or service. If a good or service is provided at less than the usual and normal charge, the amount of the in-kind contribution is the difference between the usual and normal charge for the good or service at the time of the contribution and the amount charged the committee. An in-kind contribution also includes any expenditure that meets the definition of a coordinated expenditure in subrule 4.53(4).

4.53(3) *Independent expenditure.* “Independent expenditure” means an expenditure by a person for goods or services, including express advocacy communication, on behalf of a candidate or a ballot issue which is not made with the knowledge and approval of a candidate or a ballot issue committee. “Independent expenditure” does not include incidental expenses (expenses of \$25 or less per incident absorbed by the volunteer which result from or arise out of the volunteer work) incurred by an individual in performing volunteer work.

4.53(4) *Coordinated expenditure.* “Made with the knowledge and approval of a candidate or ballot issue committee” means that there has been arrangement, coordination, or direction by the candidate or an agent or officer of the candidate’s committee or a ballot issue committee prior to the procurement or purchase of the good or service, or the publication, distribution, display, or broadcast of an express advocacy communication. This may also be referred to as a “coordinated expenditure.” An expenditure will be presumed to be coordinated when it is:

a. Based on information provided to the expending person by the candidate, the candidate’s committee, or the ballot issue committee with a view toward having an expenditure made; or

b. Made by or through any person who is or has been authorized to raise or expend funds; who is or has been an officer of the candidate’s committee or the ballot issue committee; or who is or has been receiving any form of compensation or reimbursement from the candidate, the candidate’s committee, or the ballot issue committee.

This rule is intended to implement Iowa Code Supplement section 68A.404.

DIVISION VI
COMMITTEE DISSOLUTION

351—4.54(68A) Committee dissolution; disposition of property; resolution of loans or debts. A committee shall not dissolve until all loans and debts are paid, forgiven, or transferred, and the remaining funds in the committee's campaign account are distributed according to Iowa Code sections 68A.302 and 68A.303 and rule 351—4.25(68A,68B). In the case of a candidate's committee, the disposition of all campaign property with a residual value of \$100 or more must be accomplished before dissolution.

4.54(1) Manner of disposition—candidates' committees. A candidate's committee shall dispose of campaign property with a residual value of \$100 or more through a sale of the property at fair market value, with proceeds treated as any other campaign funds, or through donation of the property as set out in Iowa Code section 68A.303(1). The candidate's committee shall disclose on the committee's campaign report the manner of disposition.

4.54(2) Resolution of loans and debts. The loans and debts of a committee may be transferred, assumed, or forgiven except that a loan or debt owed to a financial institution, insurance company, or corporation may not be forgiven unless the committee is a ballot issue committee. The committee shall disclose on the committee's campaign report the transfer, assumption, or forgiveness of a loan or debt on the appropriate reporting schedules.

4.54(3) Settlement of disputed loans and debts. A dispute concerning a loan or debt may be resolved for less than the original amount if the committee discloses on the committee's campaign report the resolution of the dispute. If the dispute is between a candidate's committee and a financial institution, insurance company, or corporation, the candidate's committee shall submit a written statement to the board describing the loan or debt, the controversy, and the steps taken to settle or collect the loan or debt. The board will review the statement and determine whether to permit the candidate's committee to report the loan or debt as discharged.

4.54(4) Unavailable creditor. If the committee cannot locate a person to whom it owes a loan or debt, the committee shall provide the board with a written statement describing the steps the committee has taken to locate the creditor and shall request direction from the board as to what additional steps, if any, should be taken. If a candidate's committee owes a loan or debt to a financial institution, insurance company, or corporation, resolution of the matter shall include payment to a charitable organization or the general fund of the state of Iowa.

This rule is intended to implement Iowa Code section 68A.402B.

351—4.55(68A) Statement of dissolution; final report; final bank statement.

4.55(1) Statement of dissolution. A statement of dissolution (Form DR-3) shall be filed after the committee terminates its activity, disposes of its funds and assets, and has discharged all of its loans and debts. The statement shall be either typewritten or printed legibly in black ink and shall be signed by the person filing the statement. A statement of dissolution filed electronically using the board's Web site is deemed signed when filed.

4.55(2) Place of filing. Statements of dissolution shall be filed with the board at 510 E. 12th Street, Suite 1A, Des Moines, Iowa 50319. Statements may also be filed by fax at (515)281-3701 or filed electronically through the board's Web site at www.iowa.gov/ethics.

4.55(3) Time of filing. A committee seeking dissolution shall file a statement of dissolution within 30 days of terminating activity, disposing of funds and assets, and discharging all loans and debts. A statement must be physically received by the board or, if mailed, must bear a United States Postal Service postmark dated on or before the required due date. Faxed or electronically filed statements must be submitted at or before 11:59 p.m. on the required due date. If the due date falls on a Saturday, Sunday, or holiday on which the board office is closed, the due date is extended to the next working day.

4.55(4) Final report. The committee shall file a final report disclosing the committee's closing transactions. Once the board staff reviews the report and determines that the committee has complied with all of the requirements of Iowa Code chapter 68A, the committee is no longer required to file

campaign reports. If the board staff determines that the committee has not complied with all of the requirements of Iowa Code chapter 68A, the committee, prior to being dissolved, shall resolve all issues.

4.55(5) *Final bank statement.* A copy of the committee's final bank statement showing the committee's closing transactions and a zero balance shall be attached to or submitted with the committee's final report. A committee participating in an election at the county, city, school, or other political subdivision level is not required to file a final bank statement unless requested to do so by the board. A committee seeking a waiver from the requirements of this subrule may do so in accordance with 351—Chapter 15.

This rule is intended to implement Iowa Code section 68A.402B.

351—4.56(68A,68B) Disposition of property for dissolution of committee. Rescinded IAB 6/22/05, effective 7/27/05.

351—4.57(68A,68B) Assumption or settlement of debts and obligations. Rescinded IAB 6/22/05, effective 7/27/05.

DIVISION VII
CIVIL PENALTIES FOR LATE REPORTS

351—4.58(68B) Late-filed campaign disclosure reports.

4.58(1) *Late reports.* A campaign disclosure report is deemed filed late if it is not received on or before the applicable due date as set out in rule 351—4.9(68A).

4.58(2) *Methods of filing.* A campaign disclosure report may be filed by any of the following methods: hand-delivered, mailed, faxed, sent as an E-mail attachment, or sent electronically via the Internet. The location for filing reports is set out in rule 351—4.8(68A,68B).

4.58(3) *Physical receipt.* A report must be physically received by the board as set out in rule 351—4.10(68A,68B).

This rule is intended to implement Iowa Code Supplement section 68B.32A(8).

351—4.59(68B) Routine civil penalty assessment for late-filed disclosure reports.

4.59(1) *Administrative resolution.* In administrative resolution of violations for late-filed disclosure reports, the board shall assess and collect monetary penalties for all late-filed disclosure reports. The board shall notify any person assessed a penalty of the amount of the assessment and the person's ability to request a waiver under rule 351—4.60(68B). A committee using the board's electronic filing system shall not be assessed a civil penalty if the board's electronic filing system is not properly functioning and causes the committee to be unable to timely file the report.

4.59(2) *County and local committee assessments.* County, county statutory, city, school, other political subdivision, and local ballot issue committees shall be assessed civil penalties for late-filed reports in accordance with the following schedule:

Date report received	First-time delinquency	Repeat delinquency by same committee in 12-month period
1 to 14 consecutive days delinquent	\$20	\$50
15 to 30 consecutive days delinquent	\$50	\$100
31 to 45 consecutive days delinquent	\$100	\$200

4.59(3) *State committee assessments.* Statewide, general assembly, state statutory, and state political committees, and a judge standing for retention shall be assessed civil penalties for late-filed reports, except for supplementary and special election reports, in accordance with the following schedule:

Date report received	First-time delinquency	Repeat delinquency by same committee in 12-month period
1 to 14 consecutive days delinquent	\$50	\$100
15 to 30 consecutive days delinquent	\$100	\$200
31 to 45 consecutive days delinquent	\$200	\$300

4.59(4) *Supplementary report assessments.* General assembly candidates' committees required to file supplementary disclosure reports shall be assessed a \$200 civil penalty for filing a supplementary report one or more days late. Statewide committees required to file supplementary disclosure reports shall be assessed a \$400 civil penalty for filing a supplementary report one or more days late.

4.59(5) *Special election assessments.* The committees of general assembly candidates to fill vacancies in special elections shall be assessed a \$100 civil penalty for filing a special election report one or more days late. The committees of statewide candidates to fill vacancies in special elections shall be assessed a \$200 civil penalty for filing a special election report one or more days late.

4.59(6) *Verified statement of registration assessments.* An out-of-state committee that chooses to file a verified statement of registration (VSR) as provided in Iowa Code Supplement section 68A.201 and rule 351—4.32(68A), but fails to file the VSR on or before the fifteenth day after the date of the contribution, shall be assessed a \$25 civil penalty per late-filed VSR. However, if there is a repeat delinquency by the committee in a 12-month period, the penalty shall be \$50.

For purposes of this subrule, "date of the contribution" means the day, month and year the contribution check is dated.

4.59(7) *Independent expenditure assessment.* A person that is delinquent in filing an independent expenditure statement shall be assessed a \$25 civil penalty for filing the statement one or more days delinquent, except that if there is a repeat delinquency by the person in timely filing an independent expenditure statement within a 12-month period, the penalty shall be \$50.

4.59(8) *Form DR-OTC assessment.* A permanent organization that has not previously made a contribution in excess of \$750 and that fails to file Form DR-OTC within ten days of notice to do so by the board shall be assessed a \$20 civil penalty. A permanent organization that has previously made a contribution in excess of \$750 and that fails to file Form DR-OTC within ten days of the date on which the contribution check is issued shall be assessed a \$20 civil penalty.

This rule is intended to implement Iowa Code Supplement section 68B.32A(8).
[ARC 7645B, IAB 3/25/09, effective 4/29/09]

351—4.60(68B) Requests for waiver of penalties. If a person believes that there are mitigating circumstances that prevented the timely filing of a report, the person may make a written request to the board for waiver of the penalty. A person seeking a waiver must submit the request to the board within 30 days of receiving a civil penalty assessment order. Waivers may be granted only under exceptional or very unusual circumstances. The board will review the request and issue a waiver or denial of the request. If a waiver is granted, the board will determine how much of the penalty is waived based on the circumstances. If a denial or partial waiver is issued, the person shall promptly pay the assessed penalty or seek a contested case proceeding pursuant to rule 351—4.61(68B).

This rule is intended to implement Iowa Code Supplement section 68B.32A(8).

351—4.61(68B) Contested case challenge.

4.61(1) *Request.* If the person accepts administrative resolution of a matter through the payment of the assessed penalty, the matter shall be closed. If the person chooses to contest the board's decision to deny the request or grant a partial waiver of an assessed penalty, the person shall make a written request for a contested case proceeding within 30 days of being notified of the board's decision.

4.61(2) *Procedure.* Upon timely receipt of a request for a contested case proceeding, the board shall provide for the issuance of a statement of charges and notice of hearing. The hearing shall be conducted in accordance with the provisions of Iowa Code section 68B.32C and the board's rules. The burden shall be on the board's legal counsel to prove that a violation occurred.

4.61(3) Failure to request hearing. Failure to request a contested case proceeding to appeal the board's decision on a waiver request is failure to exhaust administrative remedies for purposes of seeking judicial review in accordance with Iowa Code chapter 17A and Iowa Code section 68B.33.

This rule is intended to implement Iowa Code Supplement section 68B.32A(8).

351—4.62(68B) Payment of penalty.

4.62(1) Where payment made. Checks or money orders shall be made payable and forwarded to: Iowa Ethics and Campaign Disclosure Board, 510 E. 12th Street, Suite 1A, Des Moines, Iowa 50319. Such funds shall be deposited in the general fund of the state of Iowa.

4.62(2) Who may make payment. Payment may be made at the person's discretion, including from funds of a committee or from personal funds of an officer of a committee.

4.62(3) Disclosure of payment. Rescinded IAB 3/25/09, effective 4/29/09.

This rule is intended to implement Iowa Code Supplement sections 68A.503 and 68B.32A(8).
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[◇] Two or more ARCs

¹ Effective date of rule 4.16 delayed by the Administrative Rules Review Committee 45 days after convening of the next General Assembly pursuant to §17A.8(9).

CHAPTER 7
PERSONAL FINANCIAL DISCLOSURE
[Prior to 7/9/03, see 351—Ch 11]

351—7.1(68B) Filing requirements and procedures.

7.1(1) *Time of filing.* All persons who are required to file a personal financial disclosure statement (Form PFD) with the board pursuant to Iowa Code section 68B.35(2) shall file the statements with the board on or before April 30 of each year following a year during which the person holds a designated position, without regard to the length of time the position was occupied by the person. A person who held a designated position who leaves that position or state employment shall have a continuing obligation to file the statement for any year or portion of a year in which the position was held prior to termination.

7.1(2) *Place of filing.* Form PFD shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. The form may also be filed by fax at (515)281-4073 or electronically using the board's Web site at www.iowa.gov/ethics.

7.1(3) *Persons holding more than one designated position.* A person who is required to file a personal financial disclosure statement for more than one position shall be required to file only one statement for the reporting year. A member of the general assembly who files a form with the secretary of the senate or the chief clerk of the house shall not be required to file the form with the board for any designated position held in the executive branch.

7.1(4) *Physical receipt.* The board must physically receive a filed Form PFD on or before April 30 of each year. If mailed, the form must bear a United States Postal Service postmark dated on or before April 30. Faxed or electronically filed forms must be submitted on or before 11:59 p.m. on the required due date. If the due date falls on a weekend or holiday, the filing deadline shall be extended to the first working day following the deadline.

7.1(5) *Period covered.* Information shall be filed on Form PFD as designated by the board and shall cover the calendar year immediately preceding the year due. However, a statement filed by a person who has left a designated position during the course of a year need only contain information covering the portion of that year that has elapsed prior to the person's leaving the position.

7.1(6) *Public record.* Rescinded IAB 9/15/04, effective 10/20/04.

This rule is intended to implement Iowa Code sections 68B.32A(5), 68B.35 and 68B.35A.
[Editorial change: IAC Supplement 4/8/09]

351—7.2(68B) Information disclosed on form.

7.2(1) *Definitions.* For the purpose of completing Form PFD, "income sources" includes those sources which are held jointly with one or more persons and which in total generate more than \$1000 of income. "Jointly" means that the ownership of the income source is undivided among the owners and that all owners have one and the same interest in an undivided possession, each with full rights of use and enjoyment of the total income. Sources of income that are co-owned but with ownership interests that are legally divisible, without full rights of use or enjoyment of the total income, need not be reported unless the person's portion of the income from that source exceeds \$1000.

7.2(2) *Spousal income.* For purposes of completing Form PFD, income earned solely by the spouse of a person subject to reporting is not income to that person and need not be reported as an income source.

This rule is intended to implement Iowa Code section 68B.35.

351—7.3(68B) Procedure for determining persons required to file with the board—distribution of forms.

7.3(1) *Persons required by statute.* In order to determine which persons in the executive branch are required by Iowa Code section 68B.35(2) to file Form PFD, the board shall contact each agency on an annual basis and provide notification of the statutory requirement. This notification shall include the name and position title of each person in the agency who filed Form PFD the previous year. Each agency, in consultation with the board, shall then determine which persons are required to file Form PFD for the next filing period and shall provide the board with the appropriate names and position titles. The board shall have the final authority to determine whether a position requires that a Form PFD be filed.

7.3(2) Boards, commissions, or authorities not named in statute. Pursuant to Iowa Code section 68B.35(2) “e,” on an annual basis the board shall conduct a review to determine if a member of any other board, commission, or authority not specifically named in Iowa Code section 68B.35(2) “e” should file Form PFD. If the board determines that Form PFD should be filed, the board shall by rule require a Form PFD to be filed.

7.3(3) Statewide candidates. A person who is a candidate for statewide office shall file Form PFD with the board on or before April 30 of the year the candidate appears on the ballot. Once nomination papers or an affidavit of candidacy is filed, the board shall notify the person of the requirement to file Form PFD. The notification shall be sent by first-class mail and shall include a blank form or information on how to obtain a blank form for filing.

7.3(4) Statewide candidates in a special election. A candidate for statewide office in a special election shall file Form PFD with the board within seven days after the certification of the candidate’s name as the nominee under Iowa Code section 43.88.

7.3(5) Distribution of forms. The board shall provide each agency with blank forms for distribution to the designated persons and shall make blank forms available via the board’s Web site at www.iowa.gov/ethics. The board shall provide each agency with the link on the board’s Web site where forms may be filed electronically. The board shall also make blank forms available via the board’s Web site.

This rule is intended to implement Iowa Code sections 68B.32A(5) and 68B.35.
[Editorial change: IAC Supplement 4/8/09; ARC 7802B, IAB 6/3/09, effective 7/8/09]

351—7.4(68B) Delinquent forms. Rescinded IAB 9/15/04, effective 10/20/04.

351—7.5(68B) Penalties.

7.5(1) Penalties for late personal financial disclosure statements. An individual holding a designated position in the executive branch who fails to timely file Form PFD shall be subject to an automatic civil penalty according to the following schedule:

Days Delinquent	Penalty Amount
1 to 14	\$25
15 to 30	\$50
31 and over	\$100

7.5(2) Additional penalty. If an individual holding a designated position in the executive branch fails to file a personal financial disclosure statement within 45 days of the required filing date, a contested case proceeding may be held to determine whether or not a violation has occurred. If after a contested case proceeding it is determined that a violation occurred, the board may impose any of the actions under Iowa Code section 68B.32D. Any action imposed under Iowa Code section 68B.32D would be in addition to an automatically assessed penalty in subrule 7.5(1).

7.5(3) Failure to file true statement. It shall be considered a violation of Iowa Code section 68B.35 for an individual holding a designated position in the executive branch to file a disclosure statement containing false or fraudulent information. Complaints concerning the filing of a false or fraudulent disclosure statement shall be handled by the procedures in Iowa Code section 68B.32B. If it is determined after a contested case proceeding that a false or fraudulent disclosure statement was filed, the board may impose any of the actions under Iowa Code section 68B.32D.

This rule is intended to implement Iowa Code sections 68B.32A(9) and 68B.35.
[Editorial change: IAC Supplement 4/8/09]

351—7.6(68B) Requests for waiver of penalties. If an individual holding a designated position in the executive branch believes that mitigating circumstances prevented the timely filing of Form PFD, the individual may make a written request to the board for waiver of the penalty. The request for waiver must be received by the board within 30 days of notification to the individual of the civil penalty assessment. Waivers may be granted only under exceptional or very unusual circumstances. The board will review

the request and issue a waiver or denial of the request. If a waiver is granted, the board will determine how much of the penalty may be waived based on the circumstances.

This rule is intended to implement Iowa Code section 68B.32A(9).
[Editorial change: IAC Supplement 4/8/09]

351—7.7(68B) Contested case challenge.

7.7(1) Request. If the individual accepts administrative resolution concerning a late-filed Form PFD through the payment of the assessed penalty, the matter shall be closed. If the individual chooses to contest the board's decision to deny the request or grant a partial waiver of an assessed penalty, the individual shall make a written request for a contested case proceeding within 30 days of being notified of the board's decision.

7.7(2) Procedure. Upon timely receipt of a request for a contested case proceeding, the board shall provide for the issuance of a statement of charges and notice of hearing. The contested case shall be conducted in accordance with the provisions of 351—Chapter 11. The burden shall be on the board's legal counsel to prove that a violation occurred.

7.7(3) Failure to request proceeding. The failure to request a contested case proceeding to contest the board's decision on a waiver request is a failure to exhaust administrative remedies for purposes of seeking judicial review in accordance with Iowa Code chapter 17A.

This rule is intended to implement Iowa Code sections 68B.32A(9) and 68B.33.
[Editorial change: IAC Supplement 4/8/09]

351—7.8(68B) Payment of penalty. The remittance shall be made payable to the "State of Iowa General Fund" and forwarded to Iowa Ethics and Campaign Disclosure Board, 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. The remittance shall be deposited in the general fund of the state of Iowa.

This rule is intended to implement Iowa Code section 68B.32A(9).
[Editorial change: IAC Supplement 4/8/09]

351—7.9(68B) Retention and availability of filed forms.

7.9(1) Public record. Forms filed with the board are a public record and shall be available for inspection and copying.

7.9(2) Internet access. Pursuant to Iowa Code section 68B.35A, the board shall record a filed Form PFD on the board's Web site at www.iowa.gov/ethics. Filed forms shall be accessible via the board's Web site for a period of at least five years from the reporting due date.

This rule is intended to implement Iowa Code sections 68B.35 and 68B.35A.
[Editorial change: IAC Supplement 4/8/09]

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[Editorial change: IAC Supplement 4/8/09]

[Filed Without Notice ARC 7802B, IAB 6/3/09, effective 7/8/09]

[◇] Two or more ARCs

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define the department's policies regarding the collection of public assistance debts. These rules outline what information must be maintained for each claim for an overpayment or other debt owed the department and how the payments are to be applied. These rules also outline the criteria for withholding part or all of federal or state refunds or other state payments owed to the debtor and how they are applied to the debtor's claim for payment of the debt.

441—11.1(217) Definitions.

"Current" shall mean that amount which is due and owing within the previous 12 months from the date of submission to the department of administrative services or that amount which is due and owing from the date the repayment agreement or court order is implemented, if less than 12 months, before the date of submission to the department of administrative services.

"Current repayment" shall mean that payment of the cumulative sum due and owing in accordance with a repayment agreement or court order for the preceding 12 months or the date of the order or agreement if the order or agreement is more recent.

"Debtor" shall mean a current or former recipient of public assistance that has been determined by the department to be responsible for the repayment of a particular debt. For food assistance, "debtor" shall include all adult members of the food assistance household participating at the time the food assistance overpayment or program violation occurred and shall include nonrecipients found guilty of violating food assistance program rules by committing an act such as, but not limited to, trafficking. For child care assistance, "debtor" may include the current or former provider or current or former recipient of child care assistance. For Medicaid, "debtor" shall include the Medicaid member and any nonmember who fraudulently receives services.

"Department" shall mean the department of human services.

"Public assistance" shall mean family investment program, food assistance, Medicaid, state supplementary assistance, PROMISE JOBS, child care assistance, refugee cash assistance, IowaCare, and HAWK-I program.

"Repayment agreement" shall mean an agreement entered into voluntarily between the department and the debtor for the repayment of debts. Agreements shall be made on Form 470-0495, Agreement to Pay a Debt, or on a notice of debt listed in subrule 11.2(2).

"Written notification" shall mean the notification sent to a debtor by the department on Form 470-1668, Notice of Setoff of an Iowa Income Tax Refund for Debts Owed the Department of Human Services, Form 470-4139, Notice of Income Offset Against State Warrants, and Form 470-4140, Notice of Income (Payroll) Offset.

[ARC 7829B, IAB 6/3/09, effective 7/8/09]

441—11.2(217) Establishment of claim.

11.2(1) Accounts. The department shall maintain an account for each debt that has occurred. The account shall contain the following:

- a. A debtor name and account number.
- b. Program in which the debt occurred.
- c. Date the debt was discovered.
- d. Inclusive dates of the debt.
- e. Total dollar amount of each debt.
- f. Primary cause of the debt.
- g. Any transaction applied to this debt.

11.2(2) Notice of debt. A claim is established when the first notice of the debt is issued to the household on one of the following forms:

- a. Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance (no longer issued).
- b. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance (no longer issued).
- c. Form 470-2891, Notice of Medical Assistance Overpayment.
- d. Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance (no longer issued).
- e. Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance (no longer issued).
- f. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance (no longer issued).
- g. Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.
- h. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance (no longer issued).
- i. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance (no longer issued).
- j. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance (no longer issued).
- k. Form 470-4179, Notice of Food Assistance Debt.
- l. Form 470-4530, Notice of Child Care Assistance Overpayment.
- m. Form 470-4668, Notice of Food Assistance Overpayment.
- n. Form 470-4683, Notice of FIP or RCA Overpayment.
- o. Form 470-4688, Notice of PROMISE JOBS Overpayment.

11.2(3) *Change in debt.* An additional notice of debt shall be issued if a change occurs in the amount or period of the debt.

11.2(4) *Collection action.* No collection action shall be initiated on:

- a. A debt for which no notice of debt has been issued to the household.
- b. A debt that is in appeal status.
- c. A debt that is in suspended status due to an exception to policy.

[ARC 7829B, IAB 6/3/09, effective 7/8/09]

441—11.3(217) Application of payment. Payment shall be applied only to debts subject to collection pursuant to subrule 11.2(4).

11.3(1) *Application of payment to single program area.*

- a. If there is more than one debt in a program, payment shall be applied :
 - (1) First to all debts which have an agreement in chronological order of discovery, and
 - (2) Then to debts which do not have an agreement in chronological order of discovery until all debts have been paid in full or the full payment amount has been exhausted.
- b. For food assistance, payment shall be applied first to all debts with an agreement and then to debts without an agreement. Within those two groupings, payment shall be applied in the following order:
 - (1) First to state-only debts in chronological order of discovery,
 - (2) Then to intentional program violation (IPV) debts in chronological order of discovery,
 - (3) Then to inadvertent household error (IHE) debts in chronological order of discovery, and
 - (4) Then to agency error debts in chronological order of discovery.

11.3(2) *Application of payment to multiple program areas.* If there are debts in more than one program area of public assistance, payments received shall be applied to those program areas as indicated by the mode of repayment (food assistance benefits, FIP benefits) or as indicated by the client at the time of payment.

11.3(3) *Application of undesignated cash payment.* If an undesignated cash payment is received, it shall be applied to each program area proportionally based on the cumulative balance of all debts in all program areas combined.

11.3(4) *Application of payment prohibited.* Rescinded IAB 11/7/07, effective 11/1/07.

441—11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages.**11.4(1) Criteria for setoff.**

a. A claim against a debtor may be made by the department for public assistance debts when:

(1) A debtor has failed to negotiate a repayment agreement for that program area of public assistance, or

(2) A repayment agreement is not current, and

(3) The cumulative balance of the applicable debts in 11.4(1)“a”(1) and (2) exceeds \$50.

b. A claim against a debtor will not be made by the department for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through grant or benefit reduction.

11.4(2) Frequency of submission. The department shall submit to the department of administrative services twice each month a list of those debtors who have a debt meeting the criteria in subrule 11.4(1).

11.4(3) Pre-setoff notice. The department shall mail written notification to a debtor to inform the debtor of the amount the department intends to claim and apply to debts in each program when:

a. The department is notified by the department of administrative services that the debtor is entitled to a state income tax refund, rebate, or other state payment;

b. The department makes claim against the debtor.

11.4(4) Method for division of joint payments. When either spouse wishes to request a division of a jointly or commonly owned right to payment, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, the spouse's proportionate share of a jointly or commonly owned right to payment, as determined by the department of administrative services, shall be released by the department of administrative services unless:

a. Other claims are made on that portion of the jointly or commonly owned right to payment, or

b. That spouse was also a member of the same household and the spouse's income and resources were or should have been considered in the calculation of public assistance.

11.4(5) Appeal rights. When a debtor wishes to contest the claim of the department, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, a hearing shall be granted pursuant to rules in 441—Chapter 7.

a. If the department is upheld in the final decision, the setoff process shall continue and the refund, rebate, or other state payment shall be applied to the appropriate delinquent debts.

b. If the department is reversed in the final decision, the debtor's refund, rebate, or other state payment shall be released to the debtor by the department of administrative services.

11.4(6) Debt setoff. If the department has not received a request for an appeal hearing or a request for division of a jointly or commonly owned right to payment within 15 days after the date the written notification is mailed, the department shall notify a debtor of the final decision regarding the claim by mailing the Debt Setoff Credit Letter, Form 470-1667, to the debtor.

11.4(7) Application of setoff. The department shall apply any setoff received from the department of administrative services as a result of this rule to the debtor's debts as indicated on the written notification mailed to the debtor and in accordance with rule 441—11.3(217).

Any amount remaining after the setoff shall be released back to the individual.

441—11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages.**11.5(1) Criteria for setoff.**

a. Debtors not participating in the food assistance program shall be subject to collection action through the treasury offset program (TOP) which includes, but is not limited to, federal salary offset and federal tax refund offset.

(1) Debtors shall be referred to TOP if they are delinquent in repaying their food assistance debt and there is a claim or combination of claims with an unpaid balance which exceeds \$25.

(2) No claim which is less than three months old or more than ten years old as of January 31 of the offset year shall be referred. EXCEPTION: Claims which have had a final judgment entered are not subject to the ten-year time limit.

(3) Debtors are delinquent in repaying their food assistance debt if:

1. A repayment agreement has not been signed and 180 days have elapsed since the due date of the demand letter as defined in 441—subrule 65.21(4) minus any days the claim was not subject to collection action because of an appeal.

2. A repayment agreement has been signed but the debtor has failed to make the agreed-upon payments and has failed to make up the missed payments. The debtor shall be referred to TOP when 180 days have elapsed since the first of the month following the month that the debtor failed to make the agreed-upon payment and has not subsequently made up the missed payment.

b. A claim against an individual will not be referred to TOP by the department of inspections and appeals (DIA) for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through benefit reduction.

11.5(2) *Setoff under TOP.* DIA shall, by December 1 of each year, submit a notification of liability for delinquent claims to the Department of the Treasury.

11.5(3) *Pre-setoff notice.* DIA shall mail Form 470-3488, Treasury Offset Program (TOP) 60-Day Notice, to a debtor identifying the amount the department intends to refer to TOP for offset.

11.5(4) *Offset fee.* For each offset that the Treasury Department effects against an individual referred to TOP, Treasury will charge the individual a fee.

11.5(5) *Appeal rights.* When an individual wishes to contest the delinquent status of a claim as identified by DIA, a written request shall be submitted to DIA within 60 days of the date of the pre-offset notice. When the request is received within the 60-day limit, a review shall be granted.

DIA shall determine if the claim is past due and legally enforceable and shall notify the individual in writing of the decision.

11.5(6) *Application of setoff.* DIA shall apply any setoff received as a result of this rule to the individual's food assistance debts.

Any amount remaining after the setoff shall be released back to the individual.

These rules are intended to implement Iowa Code sections 217.34, 234.12, 239B.14, and 249A.5.

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CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

“Emergency management coordinator” means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

“Household” means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

“Necessary expense” means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

“Safe, sanitary, and secure” means free from disaster-related health hazards.

“Serious need” means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

441—58.2(29C) Program implementation. The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a declaration of a state of disaster emergency and shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

441—58.3(29C) Application for assistance. To request reimbursement for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the county emergency management coordinator along with receipts for the claimed expenses.

58.3(1) Application forms are available from county emergency management coordinators and local offices of the department of human services, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application shall include:

- a. A declaration of the household’s annual income, accompanied by:
 - (1) A current pay stub, W-2 form, or income tax return, or
 - (2) Documentation of current enrollment in an assistance program administered by the department of human services, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or other subsidy program.
- b. A release of confidential information to personnel involved in administering the program.
- c. A certification of the accuracy of the information provided.
- d. An assurance that the household had no insurance coverage for claimed items.
- e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.
- f. A short, handwritten narrative of the disaster event and how the disaster caused the loss being claimed.

- g. A copy of a picture identification document for each adult applicant.
- h. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance or the claim is less than the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is \$5,000. Reimbursement is available under the program for the following disaster-related expenses:

58.5(1) Reimbursement may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, up to a maximum of \$560, including:

(1) Equipment and furnishings, up to a maximum of \$560.

(2) Food, up to a maximum of \$50 for one person plus \$25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of \$30 per person and \$150 per household.

c. Clothing and bedroom furnishings, up to a maximum of \$875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of \$250 per person.

(2) Clothing, up to a maximum of \$145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of \$40.

(2) Dehumidifier, up to a maximum of \$150.

(3) Sump pump (in a flood event only), up to a maximum of \$200 installed.

(4) Electrical or mechanical repairs, up to a maximum of \$1,000.

(5) Water heater, up to a maximum of \$425 installed.

(6) Vehicle repair, up to a maximum of \$500.

(7) Heating and air-conditioning systems, up to a maximum of \$2,100 installed. Air conditioning is covered only with proof of medical necessity.

58.5(2) Reimbursement may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of \$5,000.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Reimbursement may be authorized for:

(1) The repair of structural components, such as the foundation and roof.

(2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

(3) Debris removal, including trees, up to a maximum of \$1,000.

c. Repairs to rental property are excluded under this program.

58.5(3) Reimbursement may be issued for temporary housing assistance, up to a limit of \$50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

441—58.6(29C) Eligibility determination and payment.

58.6(1) The county emergency management coordinator or designee shall:

a. Confirm that:

(1) The address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area, and

(2) Disaster-related expenses were possible as a result of the current disaster.

b. Submit the household's application form to the Homeland Security and Emergency Management Division, Camp Dodge, Building W-4, 7105 NW 70th Avenue, Johnston, Iowa 50131. The envelope shall be marked "IIAGP application."

58.6(2) The homeland security and emergency management division of the department of public defense shall:

a. Review the application.

b. Submit the household's application form to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The envelope shall be marked "IIAGP application."

58.6(3) Designated disaster staff in the department of human services shall:

a. Determine eligibility and the amount of payment.

b. Notify the applicant household of the eligibility decision.

c. Authorize payment to an eligible household.

d. Process appeals.

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.* The household may request reconsideration of the department's decisions regarding eligibility and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the department's letter notifying the household of its decision.

b. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the Iowa individual assistance grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) Exhaustion of funds. The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. “First-come, first-served” is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds shall be reserved for final appeal decisions reversing the department’s denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued shall be denied.

These rules are intended to implement Iowa Code chapter 29C as amended by 2007 Iowa Acts, House File 896.

441—58.9 to 58.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]

PREAMBLE

This division implements the emergency assistance program, which is designed to assist families who face homelessness or other types of emergencies. The purpose of the program is to provide financial assistance on behalf of a needy child or children and any other members of the household to meet needs that have been caused by an emergency and that the household is unable to fulfill. The program provides a means to deal with financial situations that threaten the health and well-being of an eligible family. It is intended to meet an immediate need that would not otherwise be met. Assistance shall not be denied even if the assistance payment will provide only a temporary resolution to an ongoing problem.

441—58.21(234) Definitions.

“*Child*” means a person under age 18 who has not reached majority through marriage. Emergency assistance shall continue through the month in which the child turns 18. “*Child*” also means a person aged 18 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training, who is expected to complete the program before reaching 19 and who has not reached majority through marriage. Emergency assistance shall continue through the month in which school or training is completed. In those cases in which the child reaches 19 in the same month as the child completes school or training, emergency assistance shall continue through the month of the child’s nineteenth birthday.

“*Destitution*” means lack of shelter because of an emergency situation.

“*Emergency*” means, for the purposes of this program, a situation that threatens the family’s living arrangements or will result in destitution unless immediate financial assistance is provided.

“*Homelessness*” means the lack of a fixed and regular nighttime residence or a residence which is:

1. A supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter).
2. A halfway house or similar institution that provides temporary residence for persons intended to be institutionalized.
3. A temporary accommodation in the residence of another person.
4. A place not designed for or ordinarily used as a regular sleeping accommodation for human beings (a hallway, a bus station, a lobby or similar places).

“*Household*” means, for the purposes of determining income, resources and household size, the following persons living in the household. The:

1. Applicant.
2. Applicant’s legal or common-law spouse.
3. Applicant’s child(ren).
4. Legal or biological parent of the child(ren).
5. Applicant’s child(ren)’s sibling(s) of whole or half blood or adoptive.

6. Applicant and any child under the care of the applicant when the applicant meets the definition of “relative” as defined at 441—paragraph 41.22(3) “a.”

Persons temporarily not living with the household at the time of the interview shall not be considered members of the household.

441—58.22(234) General provisions. Emergency assistance is available to families with children (including migrant families), who are faced with a crisis situation causing a threat to the families’ living arrangements. Emergency assistance is also available to children who are living on their own but who have been living, within the six months prior to applying for the program, with a relative as defined at 441—paragraph 41.22(3) “a,” provided an emergency exists. The program is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expended prior to the end of the fiscal year, the program will be discontinued until funding is received for the next fiscal year in accordance with rule 441—58.30(234). Emergency assistance is not intended as a substitute for regular assistance grants from an ongoing program but is intended to be the program of last resort when no other sources of assistance are available. Emergency assistance shall also be provided for that portion of an emergency need not covered by benefits from other programs due to those programs’ limitations.

441—58.23(234) Application procedures.

58.23(1) Date of application. The date of application shall be determined by the date a signed Form 470-2762, Emergency Assistance Application, is received in any local office or department-designated site. 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. To be considered valid, the application must contain a legible name and address and must be signed.

a. The emergency assistance case record must contain a completed application for each 30-day eligibility period. Whenever an initial application is denied, withdrawn, or more than 30 days old, the household shall be required to complete a new application form.

b. At least one face-to-face interview shall be conducted before approval of the application. The face-to-face interview may be held in the county office, at a department-designated site, or in the applicant’s home.

(1) The applicant may appoint an authorized representative to attend the interview if the applicant is unable to attend. The authorized representative must be a person knowledgeable of the household’s circumstances.

(2) If the applicant or authorized representative fails to attend the required interview, the application shall be denied.

(3) When it is impossible to hold a face-to-face interview within the ten-day time frame for processing applications as described at 58.23(2), the county office or department designee may waive the face-to-face interview and hold a telephone conference instead.

c. The household’s declaration shall be accepted except when verification is required by these rules or information appears questionable. The decision with respect to eligibility shall be based largely on information provided by the household.

58.23(2) Time limits. Applications shall be processed within ten calendar days from the date of receipt to resolve the household’s emergency. The ten-day time standard for approval shall apply except in unusual circumstances, such as when the department and the household have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expires; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

58.23(3) Additional information required. When additional information or verification is required, the household shall be requested in writing to provide that information within five calendar days. The written request shall also inform the household that failure to provide the required information within five calendar days or failure to authorize the local office to secure the information from other sources will result in denial of the application. The five-day period begins the day after the date the local office issues the written request.

The five-day time limit to provide additional information shall be extended if the household is unable to obtain the information by the requested date due to circumstances beyond the household's control, such as illness, or the source who is to provide the verification causes a delay, or due to emergencies like fire, flood, etc.

58.23(4) *Basis for decision on application.* The decision with respect to eligibility for emergency assistance shall be made based on the household's circumstances as they exist on the date of the interview.

58.23(5) *Subsequent requests for assistance.* Except for verifying that an emergency exists and applying for benefits from LIHEAP, general relief, or veterans affairs, the household is not required to reverify eligibility factors for approval of additional emergency assistance payment requests made within the 30-day authorization period. The time limits for processing additional requests for assistance remain the same as initial requests.

441—58.24(234) Eligibility requirements. A household, including a migrant household, shall be eligible for emergency assistance when the following conditions are met:

58.24(1) *Existence of an emergency.* An emergency shall exist, limited to eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. An emergency does not exist for gas or electricity shutoff when a household is approved for LIHEAP and is protected by the moratorium on disconnection between November 1 and March 31.

a. An emergency also exists when there is a potential for eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. For a household to qualify for emergency assistance, the potential emergency shall be expected to happen within the month of application or the following month.

b. The household shall be required to provide proof that an emergency exists. Acceptable verification includes, but is not limited to:

- (1) An eviction notice.
- (2) A foreclosure notice.
- (3) A utility shutoff notice.
- (4) A written statement to verify homelessness from the party or shelter where the household is staying.
- (5) Other written documentation, as needed.

c. If the amount necessary to resolve the emergency exceeds the \$500 maximum payment of the emergency assistance program, the applicant must be able to verify the ability to pay the difference from other resources, or the emergency assistance application shall be denied.

58.24(2) *Income and resources.* The household's available income and resources shall be within the limits as defined at rules 441—58.26(234) and 441—58.27(234).

58.24(3) *Receipt of assistance.* The household shall not have received assistance in Iowa from the program within one year prior to the date the first payment is authorized. The 12-month period begins on the date the first payment is approved. If any household member received emergency assistance within the past 12 months, the entire household is ineligible.

58.24(4) *Child in household.* The household shall contain at least one child who is living with the household.

58.24(5) *Child in need.* To be considered in need, the child shall be destitute or be without living arrangements unless assistance is provided.

a. The child is not in destitution or need if in the 30 days before application or subsequent request for emergency assistance a member of the household (including the child aged 16 or older who is not attending elementary, secondary or the equivalent level of vocational or technical school full-time) who does not have acceptable reasons for nonparticipation as described at 441—subrule 93.14(4) or barriers to participation as described at 441—subrule 93.4(5):

- (1) Refused a job offer or training for employment.
- (2) Was dismissed from a job due to the member's own actions which meet the definition of "misconduct" in 441—subparagraph 93.13(2) "i"(1).
- (3) Quit employment.

- (4) Reduced earnings.
- (5) Began participation in a strike.
- (6) Chose a limited benefit plan.

b. The 30-day period of ineligibility shall begin the day after the household member reduced earnings or was dismissed from a job.

(1) When a member quits a job, participates in a strike, or refuses employment, each day the job or offer for employment remains available or the household member participates in a strike is considered a day of job refusal. In these situations, the 30-day period of ineligibility shall begin the day the person returns to the job or accepts the job offer or the day after the job or offer for employment is no longer available.

(2) When a person chooses a first limited benefit plan, each day the person fails to reconsider by contacting IM or PROMISE JOBS counts as a day of refusal. The day the person reconsiders begins the 30-day period of ineligibility. When a person chooses a subsequent limited benefit plan, the 30-day ineligibility period shall begin the day after the date on the notice of decision establishing the person's limited benefit plan.

c. Whenever the household is determined to have good cause for refusing employment, quitting employment, or reducing earnings for the family investment program, no further determination is required for the emergency assistance program. Verification of the circumstances resulting in refusal, loss, or reduction of employment is not required unless information provided appears questionable.

58.24(6) *Application for other benefits.* The household shall apply for and accept benefits for which the household may be qualified from the energy assistance, county general relief and veteran's affairs programs before approval for emergency assistance.

a. Verification that the household has met the requirements of first seeking assistance from these programs shall be documented on Form 470-2804, Disposition of Application for Other Benefits. A separate form shall be completed for each program to which the applicant is referred.

b. Emergency assistance benefits shall not be approved while an application for other benefits is pending.

c. If a household is denied general relief within 30 days before emergency assistance application, and the denial was due to failure to work off past general relief assistance, emergency assistance shall also be denied.

58.24(7) *Citizenship and alienage.* The household shall contain at least one child who meets citizenship and alienage requirements as defined at 441—subrule 41.23(5). The household shall verify the alien status of at least one child to determine if the household contains an eligible child. There is no need to reverify the alien status unless it is subject to change.

58.24(8) *Utility service connection.* Applicants shall provide verification from the utility company that all requirements to provide service have been met before payment to the utility company for utility deposits for new or reconnected service will be approved. When a household applies for emergency assistance due to a disconnect notice, the household must provide verification from the utility company that the applicant either has signed a payment plan or is not eligible for a payment plan. Failure to provide this verification shall result in denial of the emergency assistance application.

441—58.25(234) *Determination of need.* Needs covered are limited to rent payments, house payments (including property taxes and homeowner's insurance if included in the house payment), rent and utility deposits, utilities, and purchase, repair, or rental of heating equipment. Utilities shall include heat (electric, gas, fuel oil, wood, etc.), lights, water, sewer, and garbage, but shall not include telephone. Heating equipment shall include, but is not limited to, furnace, space heater, kerosene heater, wood stove, etc. Air conditioners shall not be funded.

441—58.26(234) *Income.* The household's nonexempt gross income, with the exception of the deductions specified at subrule 58.26(2), shall not exceed 100 percent of the poverty level of the Office of Management and Budget (OMB). Changes in OMB's poverty guidelines shall go into effect the second month after the changes are published. When determining income and household size,

the household shall be determined as defined in rule 441—58.21(234). All income reported by the household shall be verified.

58.26(1) *Income considered.* Income considered shall include, but is not limited to, all gross income received or reasonably anticipated to be received by the household in the month of application, such as the family investment program (FIP) grant, veteran's pension, social security benefits, supplemental security income (SSI), job insurance benefits, child support income, alimony, workers' compensation benefits, cash payments from any of the DHS diversion programs, adoption subsidies, foster care payments, retroactive payments from any source, lump-sum income, earnings from on-the-job training, work-study income, income tax refunds (if received in the month of application), loans and grants available for living expenses (including unprorated gross educational moneys received in the month of application that are not earmarked), interest income (if received in the month of application), maintenance payments, Volunteers in Service to America (VISTA) payments, gifts, refunds from rental and utility deposits, earned income credit, self-employment income (net profit expected to be received in the month of application, not annualized), earnings from employment, and earnings of a child aged 16 or over who is not attending elementary, secondary or the equivalent of vocational or technical school full-time. The following deductions shall be allowed from earned income:

a. The actual, verified amount of employment-related, nonreimbursed child care expenses incurred or reasonably expected to be incurred in the month of application. A child care deduction shall also be allowed for VISTA volunteers.

b. Allowable business expenses in a self-employment enterprise, as defined at 441—subrule 41.27(2).

58.26(2) *Exempt income.* Exempt income shall include reimbursements; earned as well as unearned income in-kind; vendor payments; earnings of a child under age 16, or age 16 or older, if the child is attending elementary, secondary or the equivalent level of vocational or technical training school full-time; training allowances designated for a specific purpose (such as those issued by the Workforce Investment Act, PROMISE JOBS, Vocational Rehabilitation Services, Food Stamp Employment and Training program, etc.); that amount of the lump sum expended for legal, medical or burial expenses; and legally obligated moneys. Legally obligated money means money that is otherwise payable to the household, but which is diverted by the provider of the payment to a third party for a household expense without the household's consent. Examples of legally obligated moneys are the amount withheld from job insurance benefits to recover an overpayment or for child support for a child not living with the household; or the amount of child support withheld from earnings for a child not living with the household.

58.26(3) *Exempt as income and resources.* Deposits into an individual development account (IDA) are exempt. The amount of the deposit is exempt as income and shall not be used in the 100 percent of poverty level eligibility test. The deposit must be deducted from nonexempt earned and unearned income that the client receives in the month of application, provided the deposit is made in the month of application. To allow a deduction, verification of the deposit must be provided within five calendar days as described in subrule 58.23(3). The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions described in 58.26(1) "a" and "b" shall be applied to earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. If the client has both earned and unearned income, the amount deposited into the IDA shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

441—58.27(234) Resources. The household's liquid resources shall not exceed \$1000. Liquid resources are limited to cash on hand, money in checking, savings or credit union accounts, and savings certificates, with the following exceptions: The balance in an individual development account (IDA), including interest earned on the IDA, is exempt as a resource. Income in any given month is not counted as a resource in the same month. When liquid resources are owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the resources. When determining countable resources, the household shall be determined as defined in rule 441—58.21(234). All other resources

are exempt. The household's declaration of the amount of liquid resources shall be accepted unless the declaration appears questionable or the amount declared is close to the resource limitation. The household is not required to apply its available resources toward the emergency as long as the resources are within the prescribed limits.

441—58.28(234) Payment.

58.28(1) *Maximum payment.* The maximum payment shall not exceed \$500 per authorization period. This amount can be applied to a single need or to several needs, not to exceed the maximum amount. Payment shall be issued in the amount of the need, not to exceed \$500. When the emergency need is greater than \$500 (or more than the maximum amount still available to the applicant, if a subsequent request is being made), emergency assistance shall be approved only when the applicant provides verification that either:

- a. The vendor will accept payment of up to \$500 (or the maximum amount available) to resolve the emergency, or
- b. Another source will supply the amount needed over and above the emergency assistance payment amount.

58.28(2) *Vendor payment.* Payment shall be issued directly to the vendor in form of a state warrant unless the vendor is a state employee.

a. Vendors shall be required to complete Form 470-2781, Approval for Vendor Payment, before payment shall be issued. The vendor shall provide a copy of IRS Form W-9, Request for Taxpayer Identification Number and Certification, if necessary, to resolve vendor name or vendor number discrepancies.

b. Form 470-2781 shall also be used to notify the vendor of the amount approved for payment. Payment is owed to the vendor in the amount approved on Form 470-2781 even if emergency assistance funds are exhausted or emergency assistance eligibility is found not to exist when system entries are made. If the household provides verification of an emergency item and the cost of the item on another document, there is no need to send Form 470-2781 to the vendor to reverify the information.

c. Payment to state employees shall be made as follows:

- (1) If the emergency assistance payment is for a service, such as furnace repair, the payment is included in the vendor's regular state paycheck as extra pay.
- (2) If the emergency assistance payment is for goods, such as rent, rent deposit, or purchase of heating equipment, payment to the vendor is processed in the form of a travel voucher.

58.28(3) *Authorization period.* The authorization period is limited to a period of 30 consecutive days in a 12-month period, and payment shall be approved if the request is received within that period. The 30-day authorization period begins on the date the first emergency assistance payment is approved for an eligible household. The household may be eligible for more than one payment as long as the total amount of all payments does not exceed the maximum amount and all requests for additional payments are received within the period of 30 consecutive days. Any portion of the maximum payment amount not used in the 30-day authorization period cannot be carried forward to a future authorization period.

58.28(4) *Returned warrants and donations to emergency assistance.* Any refunds of emergency assistance money shall be returned to the DHS county office. Returned funds shall be deposited back into the emergency assistance account.

a. When an emergency assistance client or vendor returns the emergency assistance warrant or returns an emergency assistance payment in the form of a money order, personal check, or cash, the county office shall accept the repayment and complete Form 470-0009, Official Receipt.

b. The department may receive refunds of rent deposits that were paid on behalf of emergency assistance clients by a combination of assistance from the emergency assistance program and other persons or organizations.

c. Donations shall be handled in the same manner as refunds and shall be deposited into the emergency assistance account.

58.28(5) *Misdirected warrants.* Replacement of an emergency assistance warrant does not apply when the warrant is inadvertently delivered to the emergency assistance client rather than the vendor,

and the client endorses it with the client's own name and cashes it. This is not an overpayment, because the warrant is issued on behalf of the same client who cashed it. It is up to the vendor to pursue the matter with the post office, the place of business that cashed the warrant, or the client and to work out possible repayment arrangements.

441—58.29(234) Notification and appeals. All emergency assistance households shall be given notice with respect to the decision on their application for assistance in accordance with 441—subrule 7.7(1). Households have the right to appeal the department's decision in accordance with rule 441—7.5(17A).

441—58.30(234) Discontinuance of the emergency assistance program. The program shall be discontinued when funds have been exhausted. To ensure equitable treatment, applications for emergency assistance shall be approved on a first-come, first-served basis until all funds have been depleted. First-come, first-served is determined by the date the application is approved for payment and entered into the emergency assistance computer system.

58.30(1) Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

58.30(2) Reserved funds. A portion of yearly emergency assistance funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have run out.

58.30(3) Untimely applications. Emergency assistance applications received after the program is discontinued for the year and more than five working days before the program begins again the next year shall be denied.

441—58.31(234) Special information received from emergency assistance clients. Rescinded IAB 10/2/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 234.6.

441—58.32 to 58.40 Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

441—58.41(217) Purpose. The rules in this division are intended to allow the department to deliver services more effectively during or following a disaster emergency declared by state or federal officials. These rules temporarily supersede departmental rules that would otherwise apply, with the primary purpose of reducing barriers to accessing and receiving services that may result from the emergency. The rules shall be tailored to meet special circumstances that arise from a specific disaster emergency and shall be time-limited.

This rule is intended to implement Iowa Code section 217.6.
[ARC 7577B, IAB 2/25/09, effective 4/1/09]

441—58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements. Normal scheduled reporting, review, recertification, redetermination, or similar requirements related to continued eligibility are amended as follows:

58.42(1) Scheduled actions due in June 2008. For the month of June 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in the most affected counties during the month. For all programs except food assistance, the designated counties are Black Hawk, Bremer, Butler, Johnson, and Linn.

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);

5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(2) *Scheduled actions due in July and August 2008.* For the months of July and August 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in any county of the state:

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(3) *Next scheduled action due.* For those households affected under subrules 58.42(1) and 58.42(2), the next report, review, recertification, or redetermination shall be scheduled as if the action due in June, July, or August 2008 had occurred. For example, if a six-month review was to have occurred in June 2008, the next review will be due in December 2008. Likewise, if a 12-month recertification was due in July 2008, the next recertification will be due in July 2009.

58.42(4) *Continuing to report and act on changes.* Other than as provided by this rule, households shall continue to comply with program requirements for reporting changes in circumstances. Good cause provisions for not reporting changes timely shall apply as provided by existing rules. The department shall continue to act on all changes reported or otherwise known to the department that may affect eligibility or benefits during the extended reporting, review, recertification and redetermination periods provided under this rule.

This rule is intended to implement Iowa Code chapters 234, 237A, 239B, 249, 249A, 249J, and 514I. [ARC 7577B, IAB 2/25/09, effective 4/1/09]

441—58.43(237A) *Need for child care services.* State child care assistance eligibility requirements concerning need for service in rule 441—170.2(237A,239B) shall be held in abeyance for households residing in governor-declared disaster counties during the months of June, July, and August 2008. Households in those counties that previously met the requirement shall be considered to continue to meet the requirement for those three months if the disaster and ensuing recovery temporarily prevent the household from otherwise meeting this requirement.

This rule is intended to implement Iowa Code section 237A.13. [ARC 7577B, IAB 2/25/09, effective 4/1/09]

441—58.44(249A,249J,514I) *Premium payments.* Individuals residing in any Iowa county declared by the governor to be a disaster area who would otherwise have their assistance under 441—Chapter 75 (medical assistance), 441—Chapter 86 (HAWK-I), or 441—Chapter 92 (IowaCare) canceled for failure to make a premium payment in the months of June or July 2008 shall not have their assistance canceled for this reason.

This rule is intended to implement Iowa Code chapters 249A, 249J, and 514I. [ARC 7577B, IAB 2/25/09, effective 4/1/09]

441—58.45(249A) *Citizenship and identity.* Citizenship and identity requirements under 441—Chapter 75 for medical assistance applicants shall be held in abeyance for the months of June, July, and August 2008, for individuals residing in counties declared disaster areas by the governor as provided in this rule.

58.45(1) An affidavit may be used to establish both citizenship and identity when other forms of verification are not available and the department is unable to obtain verification through a match with vital records maintained by the department of public health.

58.45(2) An individual approved for medical assistance under this rule shall be granted a certification period of only three months. At the end of the three-month period, the individual shall be required

to provide documentation of citizenship and identity as otherwise required under 441—Chapter 75 to continue eligibility.

This rule is intended to implement Iowa Code chapter 249A.
[ARC 7577B, IAB 2/25/09, effective 4/1/09]

441—58.46 to 58.50 Reserved.

DIVISION IV
IOWA UNMET NEEDS DISASTER GRANT PROGRAM

PREAMBLE

This division implements a new program of state assistance to address unmet disaster-related expenses that cannot be met by other financial assistance, as authorized by 2009 Iowa Acts, Senate File 64. The rules provide for reimbursement for repair or replacement of personal property, home repair, mental health services, food assistance, child care, and temporary housing to households whose income is less than 300 percent of the federal poverty guidelines. The amount of assistance available to a household is capped at \$2,500.

The program is administered by the department of human services in coordination with the recovery Iowa office and local long-term recovery committees established in affected areas. The long-term recovery committees will receive applications from affected households and will certify the households' residence and unmet disaster-related expenses and determine eligibility for assistance. Department staff will issue payments and process any appeals.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.51(83GA, HF64) Definitions.

“Department” means the Iowa department of human services.

“Household” means all adults and children who lived in the pre-disaster residence who request individual assistance (not including landlords or other businesses), as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

“Iowa disaster recovery case management” means the entity that oversees the operation of local long-term recovery committees, including ensuring that each county declared a presidential disaster area on and after May 24, 2008, and before August 14, 2008, has a long-term recovery committee.

“Long-term recovery committee” means a county-based committee that performs direct work with households seeking assistance for unmet needs and certifies the assistance that each household may receive. The committee operates the voucher system for certified goods and submits documented claims to the department for reimbursement of voucher-related expenses.

“Unmet need” means an item or service needed to overcome a disaster-related hardship, injury, or adverse condition due to an eligible federally declared disaster resulting in costs or damages related to personal property, home repair, food assistance, mental health assistance, child care, or temporary housing for which the household has not received adequate assistance from any federal, state, nonprofit, or faith-based agency.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.52(83GA, HF64) Program implementation. The Iowa unmet needs disaster grant program (IUNDGP) shall be in effect upon enactment on February 2, 2009, and shall be retroactively applicable to May 24, 2008. Within the funds appropriated, this program is available for households affected by natural disasters in areas that the President of the United States declared a disaster area after May 24, 2008, and before August 14, 2008.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.53(83GA, HF64) Application for assistance. To request financial assistance for unmet disaster needs expenses, the household shall complete Form 470-4689, Iowa Unmet Needs Disaster Grant Application, and submit the application to the local long-term recovery committee.

58.53(1) Application forms are available from the local long-term recovery committee or the rebuild Iowa office. Individuals can find their local long-term recovery committee by calling the rebuild Iowa office toll-free at (866)849-0323.

58.53(2) The application shall include:

- a. A declaration of the household's annual gross income.
- b. A release of confidential information to personnel involved in administering the program.
- c. An assurance that the household had no insurance coverage for claimed items.
- d. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration.
- e. A short, written narrative of the disaster event and how the disaster caused the loss being claimed.
- f. A copy of a photo identification document for each adult applicant.
- g. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.54(83GA, HF64) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.54(1) The household's residence was located in the area identified by a presidential disaster declaration occurring on or after May 24, 2008, and before August 14, 2008, and the household verifies occupancy at that residence.

58.54(2) Household members are citizens of the United States or are legally residing in the United States.

58.54(3) The household's self-declared annual income is at or less than 300 percent of the federal poverty level for a household of that size.

- a. Poverty guidelines are updated annually.
- b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.54(4) The household has disaster-related expenses not covered by insurance, or the claim is less than or equal to the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.54(5) The household has not previously received assistance from this program or another program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration, for the same loss.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.55(83GA, HF64) Eligible categories of assistance. The maximum assistance available to a household for a single disaster is \$2,500. Reimbursement is available under the program for the following disaster-related expenses:

1. Personal property.
2. Home repair.
3. Food assistance.
4. Mental health assistance.
5. Child care.
6. Temporary housing.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.56(83GA, HF64) Eligibility determination and payment.

58.56(1) *Committee duties.* The long-term recovery committee shall enter into an agreement with the department. The committee shall perform the following duties, including specifying who is approved to certify eligibility for unmet needs grants on behalf of the long-term recovery committee.

- a. Accept the household's application.
- b. Certify that:
 - (1) The address provided on the application is a valid address in the disaster-affected area,
 - (2) Disaster-related expenses were a result of the covered disaster,
 - (3) The household has presented reasonable documentation or receipts for expenses incurred, or has reasonable estimates for eligible costs for issuance of a voucher to secure specific eligible goods or services to be obtained, and
 - (4) Funds remain available.
- c. Determine the amount of assistance the household is eligible to receive by category of assistance and provide the rationale for that amount.
- d. Provide the signature of long-term recovery committee staff making the certification and the date of certification.
- e. Notify the applicant household of the certification decision.
- f. Submit a copy of the household's Form 470-4689, Iowa Unmet Needs Disaster Grant Application, to:
 - (1) The Rebuild Iowa Disaster Recovery Case Management, Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa 50319, and
 - (2) The Department of Human Services, Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

58.56(2) *Committee administrative expenses.* The department shall pay each long-term recovery committee a fee for administrative costs equal to 3 percent of paid grants the committee processes each month.

58.56(3) *Duties of disaster case management office.* Designated disaster staff in the rebuild Iowa disaster case management office shall:

- a. Ensure that a long-term recovery committee is available in each county affected.
- b. Coordinate contact between applicants and their long-term recovery committee.
- c. Support the first-level reconsideration process.

58.56(4) *Duties of the department.* Designated disaster staff in the department of human services shall:

- a. Process grant payments to the household or vendor and administrative fee payments to the long-term recovery committee.
- b. Support the second-level reconsideration process.
- c. Process appeals.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.57(83GA, HF64) Contested cases.

58.57(1) *First-level reconsideration.* The household may request reconsideration of the long-term recovery committee decision regarding certification of eligible unmet needs and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the Rebuild Iowa Disaster Recovery Case Management, Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa 50319, within 15 days of the date of the long-term recovery committee's notification to the household of its certification decision.

b. The rebuild Iowa disaster recovery case management shall review any additional evidence or documentation submitted, issue a reconsideration decision within 15 days of receipt of the request, and notify the household of the reconsideration decision.

58.57(2) Second-level reconsideration. The household may request reconsideration of the rebuild Iowa disaster recovery case management decision regarding certification of eligible unmet needs and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the Iowa Department of Human Services, Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the notification to the household of the first-level reconsideration decision from rebuild Iowa disaster recovery case management.

b. The department shall review any additional evidence or documentation submitted, issue a reconsideration decision within 15 days of receipt of the request, and notify the household of the reconsideration decision.

58.57(3) Appeal. The household may appeal the department reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the second-level reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department. [ARC 7603B, IAB 3/11/09, effective 2/11/09]

441—58.58(83GA, HF64) Discontinuance of program. The Iowa unmet needs disaster grant program administered under this chapter shall be discontinued upon exhaustion of allocated funds or on June 30, 2010, whichever occurs first.

[ARC 7603B, IAB 3/11/09, effective 2/11/09]

These rules are intended to implement 2009 Iowa Acts, House File 64, division II.

441—58.59 and 58.60 Reserved.

DIVISION V
TICKET TO HOPE PROGRAM

PREAMBLE

This division implements the ticket to hope program, a mental health counseling program funded through a social services emergency disaster relief grant that was authorized by Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009. The program pays for professional mental health evaluation and treatment services for individuals and families who have been affected by the weather-related disasters of 2008.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.61(234) Definitions.

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

“*Ticket to hope*” means the mental health counseling program for individuals and families who have been directly affected by the weather-related disasters of 2008.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.62(234) Application process. The process for obtaining assistance from the ticket to hope program is as follows:

58.62(1) A person requesting assistance shall contact the Iowa concern hotline by telephone at 1-800-447-1985.

58.62(2) The Iowa concern hotline shall gather information and determine eligibility for ticket to hope services based on criteria established in this division.

58.62(3) The Iowa concern hotline shall send to each eligible applicant a packet of information that includes:

a. An introductory cover letter;

- b. A list of participating providers;
- c. An authorization form for one 45- to 50-minute session (valid for 30 days); and
- d. A demographic data form that includes a unique numeric client identifier.

58.62(4) The eligible applicant shall:

- a. Make an appointment with an approved provider; and
- b. Give the authorization and demographic data forms to the provider at the time of the appointment.

58.62(5) After the eligible applicant meets with the provider, the applicant may call the Iowa concern hotline and receive authorization for up to seven additional sessions. A new authorization form shall be issued for each session.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.63(234) Eligibility criteria. To be eligible for assistance, a person living in Iowa must report:

1. That the impact of the 2008 disaster has impaired the person's ability to carry out normal daily functions to some extent; and
2. That the person has no insurance coverage for mental health services, or has insurance with a high deductible that will deter the person from accessing necessary mental health services.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.64(234) Provider participation. A mental health professional with an active professional license issued by the Iowa department of public health who is qualified to provide individual psychotherapy (i.e., Current Procedural Terminology code 90806, "individual psychotherapy, insight-oriented behavior modification or support, provided face to face with the patient in an office or outpatient setting") according to the Iowa Plan vendor requirements shall be allowed to participate as a ticket to hope provider.

58.64(1) A mental health professional applying to participate in the program shall submit a copy of the professional license to the Iowa concern hotline.

58.64(2) The mental health professional shall agree to the terms of participation in the ticket to hope program by:

- a. Signing a professional services agreement with the department; and
- b. Returning the signed agreement to the Iowa concern hotline.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.65(234) Provider reimbursement. A provider approved to participate shall be reimbursed as follows:

58.65(1) The provider shall submit a completed demographic data form and the authorization form to the Iowa concern hotline within 30 days after each completed session with an approved applicant.

58.65(2) The provider shall be reimbursed at the lower of:

- a. A rate of \$93 per assessment or counseling session, or
- b. The prevailing Iowa Medicaid rate.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.66(234) Reconsideration. An applicant may request reconsideration of a denial of access to services. A mental health professional may request reconsideration of a denial to be a part of the professional provider panel.

58.66(1) To request reconsideration, the person shall submit a written request to the DHS Division of Mental Health and Disability Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

58.66(2) The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days from receipt of the request.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.67(234) Appeal. The person may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

58.67(1) Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

58.67(2) A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—58.68(234) Discontinuance of program. The program shall end on June 30, 2010, or when the funds are expended, whichever occurs first.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 234.6.

[Filed emergency 10/12/90 after Notice 8/22/90—published 10/31/90, effective 11/1/90]

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[Filed ARC 7577B (Notice ARC 6995B, IAB 7/30/08), IAB 2/25/09, effective 4/1/09]

[Filed Emergency ARC 7603B, IAB 3/11/09, effective 2/11/09]

[Filed Emergency ARC 7641B, IAB 3/25/09, effective 3/1/09]

[Filed ARC 7830B (Notice ARC 7642B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]

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 agreement to pay an adoption subsidy 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 is currently paying an adoption subsidy for the child.

d. The state paying the adoption subsidy:

(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 of Medicaid-eligible mothers.* 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. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child lives with the mother and the mother remains eligible for Medicaid or would be eligible if she were still pregnant or qualified for emergency services for childbirth.

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 185 percent of the federal poverty level for pregnant women when establishing initial eligibility under these provisions and for infants (under one year of age) when establishing initial and ongoing eligibility. 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 in accordance with the provisions of rule 441—75.57(249A).

In determining eligibility for pregnant women and infants, after the aforementioned disregards and deductions have been applied, an additional disregard equal to 15 percent of the applicable federal poverty level shall be applied to the family's income.

(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 the following percentage 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) 85 percent effective January 1, 1989.
- (2) 90 percent effective January 1, 1990.
- (3) 100 percent effective January 1, 1991, and thereafter.
- (4) Rescinded IAB 1/9/91, effective 1/1/91.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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 line is published.

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 the following percentage 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) 110 percent effective January 1, 1993.
- (2) 120 percent effective January 1, 1995, and thereafter.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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 twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.
- 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	\$25
180% of Federal Poverty Level	\$40
220% of Federal Poverty Level	\$55
250% of Federal Poverty Level	\$70
280% of Federal Poverty Level	\$85
310% of Federal Poverty Level	\$100
340% of Federal Poverty Level	\$120
370% of Federal Poverty Level	\$140
400% of Federal Poverty Level	\$165
430% of Federal Poverty Level	\$190
460% of Federal Poverty Level	\$220
490% of Federal Poverty Level	\$255
530% of Federal Poverty Level	\$295
575% of Federal Poverty Level	\$340
620% of Federal Poverty Level	\$390
670% of Federal Poverty Level	\$452

(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, income shall include all earned and unearned income as defined for purposes of the Supplemental Security Income program by 20 CFR Sections 416.1102, 416.1103, 416.1110, 416.1111, and 416.1120 to 416.1123 as amended to August 20, 2008, without regard to exclusions or deductions from income applied in determining eligibility for Supplemental Security Income.

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

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]

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 470-2304, 470-2304(S), 470-0364, 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 470-2304, 470-2304(S), 470-0364, 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]

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 precertified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules 191—Chapter 72. A person 65 years of age or older who is either the beneficiary of a certified long-term care policy or enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 72 and who is eligible for medical assistance under 75.1(3), 75.1(4), 75.1(5), 75.1(6), 75.1(7), 75.1(9), 75.1(12), 75.1(13), 75.1(17), 75.1(18), 75.1(23) or 75.1(27) except for excess resources may be eligible for medical assistance under this subrule if the excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule. “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s long-term care policy for qualified Medicaid long-term care services.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4 and chapter 249G.

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 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 as defined in subrule 75.11(1) residing in the United States prior to August 22, 1996.
 - (3) A qualified alien who entered the United States on or after August 22, 1996, and who is:
 - A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
 - Granted asylum under Section 208 of the Immigration and Nationality Act;

- An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or

- A veteran with a discharge characterized as an honorable discharge and not on account of alienage, an alien who is on active duty in the Armed Forces of the United States other than active duty for training, or the veteran's spouse or unmarried dependent child.

(4) A qualified alien who entered the United States on or after August 22, 1996, and 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 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 status by signing the application form which contains a similar declaration at time of review.

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.

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
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

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
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.

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 is a veteran or a surviving spouse of a veteran who receives a pension subject to limitation of \$90 after the month of entry pursuant to 38 U.S.C. Section 5503, the veteran or the surviving spouse of a veteran shall retain \$90 from the veteran's pension beginning the month after entry to a medical institution. The \$90 allowance from a veteran's pension is in addition to the \$50 allowance from any other income.

(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. 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.

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 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 directly.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

- a. There was a serious illness or death of the parent or a member of the parent's family.
- b. There was a family emergency or household disaster, such as a fire, flood, or tornado.
- c. The parent offers a good cause beyond the parent's control.
- d. 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.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

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) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness 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 an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

- a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs \$50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs \$100 or

less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of \$50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When it 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, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) 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.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, 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.

75.21(6) Duplicate policies. When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a

Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

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, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy 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 policyholder ten calendar days in which to provide it.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage 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 cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875, is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the 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 policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) Method of premium payment. Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the 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 policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums. The department shall issue reimbursement to the policyholder five working days prior to the policyholder'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 said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

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.* Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder 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).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. 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. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department shall verify whether insurance may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying 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 insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.* An adequate notice shall be provided to the household under the following circumstances:

- a. To inform the household of the initial decision on cost-effectiveness and premium payment.
- b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.
- c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient 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 policy 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 recipient'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.

This rule is intended to implement Iowa Code section 249A.3.

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.

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 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 trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.
- (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 (4) of this paragraph.

(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 less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The annuity was purchased before February 8, 2006; or

(2) The annuity was purchased on or after February 8, 2006, and a condition described in 75.23(9) "a"(1) to (4) was 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 less 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]

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.

“*Group health insurance*” shall mean any plan of, or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer’s employees, former employees, or the families of the employees or former employees.

“*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.

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. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)“j”(2).

75.51(1) Exception to time limit. Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

75.51(2) Cancellation for failure to return review form. When all eligibility factors are met, assistance shall be reinstated when a completed Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), is received by the department within ten days of the date a cancellation notice is sent to the member because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs.

a. Reviews shall be conducted using information contained in and verification supplied with Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document.

b. Family medical assistance-related medically needy recertifications shall be conducted using information contained in and verification supplied with Form 470-3118 or 470-3118(S), Medicaid Review.

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. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), with the following exceptions:

a. 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 semiannual or annual review.

b. Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), 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 Form 470-2881, 470-2881(M), 470-4083(Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), or Form 470-3118 or 470-3118(S), Medicaid Review, when requested by the department in accordance with these rules. The department shall supply the form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the 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 review month.

(2) When the 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 it is mailed by the department.

(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."

(4) A copy of a form received by fax or electronically shall have the same effect as an original form.

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).

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, from investment and nonrecurring lump sum payments, 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, 470-0486, 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) The expense shall be verified by a receipt or a statement from the provider of care and shall be allowed when paid to any person except a parent or legal guardian of the child or another member of the eligible group, or to 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 stamp allotment in the food stamp program 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 stamp allotment in the food stamp program 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 coupon allotment in the food stamp program.

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 during the 30 days before the application date to project future income. EXCEPTION: If the applicant provides verification that the 30-day period specified above 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. 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.

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 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Payments to health care providers that are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

Providers are reimbursed throughout each fiscal year on the basis of a projected monthly rate for each participating provider, based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles) with annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider

on financial and statistical reports. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

The methodology for determining the reasonable and proper cost for service provision assumes the following:

- (1) The indirect administrative costs shall be limited to 20 percent of other costs.
- (2) Mileage shall be reimbursed at a rate no greater than the state employee rate.
- (3) The rates a provider may charge are subject to limits established at 79.1(2).
- (4) Costs of operation shall include only those costs which pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) Basis of reimbursement of specific provider categories.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/08 plus 1%. Air ambulance: Fee schedule in effect 6/30/08 plus 1%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/08 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Behavioral health services	Fee schedule	Fee schedule.
Birth centers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/08 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or \$22.12 per half-day, \$44.03 per full day, or \$66.03 per extended day if no Veterans Administration contract. For mental retardation waiver: County contract rate or, in the absence of a contract rate, \$29.47 per half-day, \$58.83 per full day, or \$75.00 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee \$49.53. Ongoing monthly fee \$38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of \$19.81 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare. For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For elderly waiver: \$82.92 per visit. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate. For AIDS/HIV and ill and handicapped waivers: Cannot exceed \$82.92 per visit.
6. Respite care when provided by: Home health agency: Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed \$296.94 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$13.12 per hour not to exceed \$296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$33.75 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	\$18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$13.12 per hour not to exceed \$296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	\$33.75 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	\$13.12 per hour not to exceed \$296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	\$13.12 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	\$13.12 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	\$13.12 per hour not to exceed \$296.94 per day.
Adult day care	Fee schedule	\$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	\$13.12 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	\$13.12 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	\$13.12 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	\$13.12 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	\$7.71 per half hour.
8. Home-delivered meals	Fee schedule	\$7.71 per meal. Maximum of 14 meals per week.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
9. Home and vehicle modification	Fee schedule	For elderly waiver: \$1010 lifetime maximum. For mental retardation waiver: \$5050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: \$6060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	\$8.25 per unit.
13. Assistive devices	Fee schedule	\$110.05 per unit.
14. Senior companion	Fee schedule	\$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	\$20.20 per hour not to exceed the daily rate of \$116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: \$1,117 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed \$36.71 per day.
Individual	Fee agreed upon by consumer and provider	\$13.47 per hour not to exceed the daily rate of \$78.56 per day.
16. Counseling		
Individual:	Fee schedule	\$10.79 per unit.
Group:	Fee schedule	\$43.14 per hour.
17. Case management	Fee schedule	For brain injury waiver: \$598.68 per month. For elderly waiver: \$70 per month.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	\$34.98 per hour, \$78.88 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.98 per hour and 26 hours per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of \$34.98 per hour for all activities other than personal care and services in an enclave setting. Maximum of \$19.81 per hour for personal care. Maximum of \$6.19 per hour for services in an enclave setting. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	\$6060 per year.
21. Behavioral programming	Fee schedule	\$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	\$43.14 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: \$37.44 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, \$48.22 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Child development home or center	Fee schedule	\$13.12 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, \$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule	\$6060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	\$34.98 per hour.
29. In-home family therapy	Fee schedule	\$93.63 per hour.
30. Financial management services	Fee schedule	\$65.65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	\$15.15 per hour.
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule based on MR/CMI/DD case management rates as set under 79.1(1)“d.”	\$598.68 per month.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour or \$105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 6/30/08 plus 1%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/08 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 7/01/08.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/08 plus 1%.
MR/CMI/DD case management providers	Monthly fee for service with cost settlement. See 79.1(1)“d”	Retrospective cost-settled rate.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)“d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)“f.” The direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)“f”(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3) “1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3) “2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Medicare fee schedule.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/08 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Podiatrists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Prescribed drugs	See 79.1(8)	\$4.57 dispensing fee. (See 79.1(8) “a,” “b,” and “e.”)

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Psychiatric medical institutions for children		
1. Inpatient	Prospective reimbursement	Rate based on actual costs on 6/30/07, not to exceed a maximum of \$167.19 per day.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost.
Rural health clinics	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/08 plus 1%.
State-operated institutions	Retrospective cost-related	

79.1(3) Ambulatory surgical centers. Payment is made for facility services on a fee schedule determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1) “c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) Reimbursement for hospitals.

a. Definitions.

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

“Average daily rate” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“Base year cost report,” for rates effective October 1, 2005, shall mean the hospital’s cost report with fiscal year end on or after January 1, 2004, and before January 1, 2005, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base amount” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Blended capital costs” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Capital costs” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix adjusted” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Case-mix index” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“Children’s hospitals” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children’s Hospitals and Related Institutions.

“Cost outlier” shall mean cases which have an extraordinarily high cost as established in 79.1(5) “f,” so as to be eligible for additional payments above and beyond the initial DRG payment.

“Critical access hospital” or *“CAH”* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

“Diagnosis-related group (DRG)” shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) “y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“Graduate medical education and disproportionate share fund” shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rate table listing*” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“*Rebasing*” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“*Recalibration*” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“*Short stay day outlier*” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)“*f.*”

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)“*r.*” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)“*r.*” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005, the recalibration for rates effective October 1, 2005, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 2004 fiscal year and paid through March 31, 2005, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using claims and associated DRG weights only for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average

case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient

remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)“r,” both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an

overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph "y."

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and

4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME,

reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)“i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)“i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the

hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.
- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)"y"(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2008, through June 30, 2009, is \$8,642,112.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)"y"(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2008, through June 30, 2009, is \$15,174,101.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for indirect medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10).

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2008, through June 30, 2009, is \$7,253,641.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid July 1, 2005, through June 30, 2006, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5) "ab" cannot exceed the amount of the federal cap under Public Law 102-234. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to

paragraphs 79.1(5) “a” to “z.” Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) “k.”

ab. Enhanced disproportionate-share payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5) “y,” payment shall be made to all Iowa hospitals qualifying for enhanced disproportionate-share payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying criteria for enhanced disproportionate-share payments. A hospital qualifies for enhanced disproportionate-share payments if it qualifies for payments for disproportionate share from the graduate medical education and disproportionate-share fund pursuant to paragraph 79.1(5) “y” and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

3. Is an Iowa state-owned hospital for persons with mental illness.

(2) Amount of payment. The total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate share shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate-share payments shall not exceed the hospital-specific disproportionate-share caps under Public Law 103-666.

The amount available for enhanced disproportionate-share payments shall be the federal allotment less disproportionate-share payments from the graduate medical education and disproportionate share fund. In the event that the disproportionate-share allotment for enhanced payments is insufficient to pay 100 percent of the cost that is eligible for disproportionate-share payments, the allotment shall be allocated among qualifying hospitals using their eligible cost as an allocation basis.

(3) Final disproportionate-share adjustment. The department’s total year-end disproportionate-share obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital’s Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

ac. Enhanced graduate medical education payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5) “y,” payment shall be made to all Iowa hospitals qualifying for enhanced graduate medical education payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying for enhanced graduate medical education payments. A hospital shall qualify for enhanced graduate medical education payments if it qualifies to receive both direct and indirect medical education payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5) “y” and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education; or

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of graduate medical education payments from the graduate medical education and disproportionate share fund and enhanced graduate medical education shall not exceed each hospital's actual medical assistance program graduate medical education costs. The amount paid to each qualifying hospital for enhanced graduate medical education payments shall be the hospital's actual medical assistance program graduate medical education costs less the graduate medical education payments from the graduate medical education and disproportionate share fund.

(3) Final graduate medical education adjustment. The department's total year-end graduate medical education obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

a. Effective June 25, 2005, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g.”

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph “g.”

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a drug and all equivalent products (the average price pharmacies pay to obtain drugs as evidenced by purchase records) adjusted by a multiplier of 1.4, plus the professional dispensing fee specified in paragraph “g.”

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Effective June 25, 2005, reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g.”

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All 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. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph “a” except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered after June 30, 2008, the professional dispensing fee is \$4.57 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8) "a"(3) and 79.1(8) "c" and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13) "b," 78.37(16) "b," 78.38(9) "b," 78.41(15) "b," 78.43(15) "b," or 78.46(6) "b."

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) Prohibition against reassignment of claims. No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to

a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of

the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when

provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph "f."

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

“*Ancillary service*” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“*APC service*” means a service that is priced and paid using the APC system.

“*Base-year cost report*,” for rates effective July 1, 2008, shall mean the hospital’s cost report with fiscal year end on or after January 1, 2006, and before January 1, 2007. Cost reports shall be reviewed using Medicare’s cost-reporting and cost reimbursement principles for those cost-reporting periods.

“*Blended base APC rate*” shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“*Cost outlier*” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“*Current procedural terminology—fourth edition (CPT-4)*” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“*Diagnostic service*” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“*Direct medical education costs*” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“*Direct medical education rate*” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“*Discount factor*” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“*Graduate medical education and disproportionate share fund*” shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“*Healthcare common procedures coding system*” or “*HCPCS*” means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“*Hospital-based clinic*” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“*International classifications of diseases—fourth edition, ninth revision (ICD-9)*” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rebasing” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“Significant procedure” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“Status indicator” or *“SI”* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPSS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPSS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPSS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. 	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

	<ul style="list-style-type: none"> Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> May be paid when submitted on a bill type other than outpatient hospital. An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
G	Pass-through drugs and biologicals	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>

H	Pass-through device categories	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	<p>Blood and blood products</p> <p>Brachytherapy sources</p> <p>Non-pass-through drugs and biologicals</p> <p>Therapeutic radiopharmaceuticals</p>	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	<p>Influenza vaccine</p> <p>Pneumococcal pneumonia vaccine</p>	<p>If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	Items and services not billable to the Medicare fiscal intermediary	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	<p>Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria.</p> <p>If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPSS APC or any other Medicaid payment system.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital’s Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)"v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Hospital billing. Rescinded IAB 07/02/08, effective 07/01/08.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the

determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)“v”(3), the total amount of funding that is allocated to the graduate medical education and

disproportionate share fund for direct medical education related to outpatient services for July 1, 2008, through June 30, 2009, is \$2,922,460.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification. Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published

by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicaid-allowed amount*” means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicaid reimbursement*” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph “b” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “b.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1) "d." Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is one month.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. One hour for enhanced job search.
- (6) A unit of supported employment habilitation supports to maintain employment is one hour.
 - b. Submission of cost reports.* The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.
 - (1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.
 - (2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.
 - (3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.
 - (4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.
 - (5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.
 - (6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24) "b," the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.
 - (7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.
 - c. Rate determination based on cost reports.* Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.
 - (1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.
 - (2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).
 - (3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7835B, IAB 6/3/09, effective 7/8/09]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) Sanctions. The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) Imposition and extent of sanction.

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- (1) Seriousness of the offense.
- (2) Extent of violations.
- (3) History of prior violations.
- (4) Prior imposition of sanctions.
- (5) Prior provision of provider education.

- (6) Provider willingness to obey program rules.
- (7) Whether a lesser sanction will be sufficient to remedy the problem.
- (8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5) "c" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) Notice of sanction. When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) Notice of violation. Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

- a. The nature of the discrepancies or violations,
- b. The known dollar value of the discrepancies or violations,
- c. The method of computing the dollar value,
- d. Notification of further actions to be taken or sanctions to be imposed by the department, and
- e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) Suspension or withholding of payments pending a final determination. Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. *Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. *Purpose.* The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. *Components.*

(1) *Identification.* Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) *Basis for service—general rule.* General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) *Service documentation.* The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d,"

441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.

2. Nursing facility physician order.

3. Telephone order.

4. Pharmacy notes.

5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.

2. Anesthesia notes and records.

3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.

2. Certifying physician statement.

3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.

2. Preanesthesia physical examination report.

3. Operative report.

4. Anesthesia record.

5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.

2. Original prescription or updated prescriptions for corrective lenses or contact lenses.

3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.

2. Psychological examination report and notes.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.

2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Remedial services and rehabilitation services for adults with a chronic mental illness:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Individual treatment plan.
 6. Reassessment of member needs.
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).

2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.
 4. Prior authorization documentation.
 5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.
 - (1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
 - (2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
 - (3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
 - (4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.
- 79.3(3) Maintenance requirement.** The provider shall maintain records as required by this rule:
 - a.* During the time the member is receiving services from the provider.
 - b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
 - c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.
- 79.3(4) Availability.** Rescinded IAB 1/30/08, effective 4/1/08.
This rule is intended to implement Iowa Code section 249A.4.

441—79.4(249A) Reviews and audits.**79.4(1) Definitions.**

“*Authorized representative*,” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) Audit or review of clinical and fiscal records by the department. Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“*d*” to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
 Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
 Reviewer Name & Phone Number: _____
 Provider Name: _____
 Provider Number: _____
 Provider Type: _____

Please sign this form and return it with the information requested.
 Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
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c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph "b."

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph "c" of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson, and a vice-chairperson.

a. Elections will be held the first meeting after the beginning of the calendar year.

b. The term of office shall be two years. Officers shall serve no more than two terms for each office.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) Alternates. Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) Expenses. The travel expenses of the public representatives and other expenses, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations.

79.7(4) Meetings. The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of such meetings. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and alternate and to the executive office of each organization or body represented.

d. Notice shall be made to the representing organization when the member, or alternate, has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties. The medical assistance advisory council shall:

a. Make recommendations on the reimbursement for medical services rendered by providers of services.

b. Assist in identifying unmet medical needs and maintenance needs which affect health.

c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

d. Reserved.

e. Reserved.

f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.

h. Advise professional groups and act as liaison between them and the department.

i. Report at least annually to the appointing authority.

j. Perform other functions as may be provided by state or federal law or regulation.

k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, regulations, laws, and guidelines, for its information, review, and comment.

- e. The department shall present the annual budget for the medical assistance program for review and comment.
- f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.
- g. The department shall maintain a current list of members and alternates on the council.

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

- (1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and
- (2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

- a. The conditions for payment outlined in the provider manual with reference to coverage and duration.
- b. The determination made by the Medicare program unless specifically stated differently in state law or rule.
- c. The recommendation to the department from the appropriate advisory committee.
- d. Whether there are other less expensive procedures which are covered and which would be as effective.
- e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department’s preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by

the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)“a”;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to the IME Surveillance and Utilization Review Services Unit, P.O. Box 36390, Des Moines, Iowa 50315; or
- (2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

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¹ Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

- ² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- 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 October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 153
FUNDING FOR LOCAL SERVICES
[Prior to 7/1/83, see Social Services[770] Ch 131]
[Previously appeared as Ch 131—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
SOCIAL SERVICES BLOCK GRANT

PREAMBLE

This division sets forth the requirements for reporting required for receipt of federal social services block grant (SSBG) funds and service availability and allocation methodology related to those funds.

441—153.1(234) Definitions.

“*Direct services*” means services provided by staff of the department of human services to clients. This includes the administrative support necessary to maintain and oversee services. Direct services are funded with state and federal dollars.

“*State purchase services*” means those services the department purchases in every county statewide. State purchase services are funded with state and federal funds.

441—153.2(234) Development of preexpenditure report.

153.2(1) The department of human services shall develop the social services block grant preexpenditure report on an annual basis. The report shall be developed in accordance with the Code of Federal Regulations, Title 45, Part 96, Subpart G, as amended to July 20, 2000. The report shall describe the services to be funded, in what areas services are available and the amount of funding available. The plan shall also indicate the source of funding.

153.2(2) The department shall issue a proposed preexpenditure report before publication of the final report. The proposed report shall be available for public review and comment:

a. In each local office where a service area manager is based during regular business hours for a two-week period; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

153.2(3) The time and scope of public review will be announced each year. The announcement will indicate the time the proposed report can be viewed. The department:

a. Shall make this information available on the department’s Internet Web site, www.dhs.iowa.gov, and post signs in each local human services office; and

b. May publish advertisements in each service area listing the time of review.

153.2(4) The department shall accept comments about the preexpenditure report during the specified public review and comment period. Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. The service area manager may arrange public hearings where testimony will be accepted.

153.2(5) The department shall consider the public comment when developing the final preexpenditure report.

153.2(6) A copy of the final preexpenditure report will be available:

a. In each local office where a service area manager is based; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

441—153.3(234) Amendment to preexpenditure report.

153.3(1) The preexpenditure report may be amended throughout the year. The department may file an amendment changing the kind, scope or duration of a service. Decisions to change a direct service or state purchase service will be made by the department.

Prior to filing an amendment the department and the county boards of supervisors will evaluate available funds and the effect any change will have on clients.

153.3(2) An amendment in the preexpenditure report will be posted in the local offices affected by the amendment at least 30 days prior to the effective date of the change. However, in the event funding for the service has been exhausted, an amendment shall be posted immediately notifying the public that the service will no longer be available. The service area manager will, whenever possible, give advance notice of a service termination made necessary because funds have been exhausted. When a service is added or extended, an amendment may be posted immediately and a 30-day posting period is not required.

153.3(3) Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

153.3(4) Nothing in this rule will supersede the requirement for notifying clients of adverse action as provided in 441—130.5(234).

441—153.4(234) Service availability.

153.4(1) A client shall apply for services in the appropriate office of the Iowa department of human services.

a. The department shall determine eligibility according to 441—130.3(234).

b. The department shall develop a case plan to monitor the client's progress toward achieving goals as identified in 441—130.7(234).

153.4(2) An eligible client shall receive a service for which the client is eligible, subject to the provisions of 441—Chapter 130, when the service is listed in the geographic area in which the client resides. The geographic area for direct and state purchase is the state.

153.4(3) To the extent federal law prohibits use of federal funds for provision of social service block grant services to persons the department has defined as eligible, state funds shall be used to pay for these services.

441—153.5(234) Allocation of block grant funds.

153.5(1) The department shall follow a cost allocation plan for determining the appropriate administrative costs to be funded with block grant money.

153.5(2) Funding for services shall be allocated in accordance with the annual budgeting process. The department's annual budget is available for review on the department's Internet Web site at www.dhs.iowa.gov. Costs may be shifted in and between service areas to ensure continued statewide availability of services.

441—153.6(234) Local purchase planning process. Rescinded IAB 7/8/92, effective 7/1/92.

441—153.7(234) Advisory committees. Rescinded IAB 3/6/02, effective 7/1/02.

441—153.8(234) Expenditure of supplemental funds. When supplemental funds are issued through the social services block grant as emergency disaster relief, the department shall administer the funds in compliance with the terms of the federal award rather than the provisions of this division.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—153.9 and 153.10 Reserved.

These rules are intended to implement Iowa Code section 234.6.

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

PREAMBLE

Decategorization of child welfare and juvenile justice funding is an initiative intended to establish systems of delivering human services based upon client needs that replace systems based upon a multitude of categorical funding programs and funding sources, each with different service definitions

and eligibility requirements. Decategorization is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

441—153.11(232) Definitions. For the purposes of this division, the following definitions apply:

“*Budget accountability*” means that expenditures for decategorization services from a decategorization project’s funding pool during the state fiscal year do not exceed the total amount of funding available in the funding pool for the state fiscal year.

“*Carryover funding*” means moneys designated for a project’s decategorization services funding pool that remain unencumbered or unobligated at the close of the state fiscal year.

“*Chief juvenile court officer*” mean the judicial department official responsible for managing and supervising juvenile court services operations within one of the eight judicial districts.

“*Decategorization*” means an initiative established pursuant to Iowa Code section 232.188 that is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of more restrictive approaches.

“*Decategorization agreement*” means the agreement entered into among representatives of the department of human services, juvenile court services, and the county government in one or more counties to implement a decategorization project in accordance with the requirements of Iowa Code Supplement section 232.188 and this division.

“*Decategorization project*” means the county or counties that have entered into a decategorization agreement to implement the decategorization initiative in the county or multicounty area covered by the agreement.

“*Decategorization services funding pool*” or “*funding pool*” means the funding designated for a decategorization project from all sources.

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

“*Governance board*” means a decategorization governance board, which is the group that enters into and implements a decategorization agreement.

“*Service area manager*” means the department official responsible for managing the department’s programs, operations, and child welfare budget within one of the eight department service areas.

“*Unencumbered or unobligated*” means funding within a decategorization services funding pool that is not spent by the project’s governance board for a specific program or purpose by the close of the state fiscal year.

441—153.12(232) Implementation requirements. The decategorization initiative shall be implemented through the creation and operation of decategorization projects. One or more counties may jointly agree to form a decategorization project to implement the initiative. The decategorization initiative shall be implemented in accordance with the following requirements:

153.12(1) *Decategorization agreement.* Representatives from the department, juvenile court services, and county government within the county or counties interested in forming a decategorization project shall develop a written agreement to work together to implement decategorization.

153.12(2) *Department approval.* A decategorization project must request and receive approval from the department director.

153.12(3) *Governance board.* A decategorization project shall be implemented by a decategorization governance board.

a. The department director shall ensure that each decategorization project has an operating governance board that includes:

(1) Representatives designated by administrators of the department and of juvenile court services; and

(2) Officials with the authority to represent county government in the affected county or counties.

b. Decategorization projects may choose to expand their governance boards to include representatives from other entities.

153.12(4) Department information. The service area manager shall provide the governance board with:

a. Information concerning the department service area's funding allocation for department-administered child welfare service programs; and

b. A copy of the service area's child welfare and juvenile justice annual plan.

153.12(5) Juvenile justice information. The chief juvenile court officer shall provide the governance board with information on the judicial district's allocation of funding for juvenile justice service programs.

153.12(6) Support and coordination. The department service area manager and the chief juvenile court officer shall:

a. Work with the governance board throughout each state fiscal year to coordinate planning and to target resources most effectively.

b. Regularly provide the governance board with available data concerning child welfare and juvenile justice needs, service trends and expenditures, child welfare and juvenile justice outcomes, and other relevant issues.

c. Work with the governance board to:

(1) Support board planning and service development; and

(2) Promote effective alignment of available financial resources to enhance preventive, family-centered, and community-based services.

441—153.13(232) Role and responsibilities of decategorization project governance boards. The governance board of a decategorization project shall have the following authority and responsibilities:

153.13(1) Rules of operation. The governance board shall establish and adopt written rules of operation that are available to the public.

153.13(2) Open meetings and records. The governance board shall adhere to statutory requirements for government bodies concerning open meetings and open records procedures as specified in Iowa Code chapters 21 and 22.

153.13(3) Coordination. The governance board shall coordinate project planning, decategorization service decisions, and budget planning activities with the service area manager and the chief juvenile court officer for the county or counties comprising the project.

153.13(4) Right to services. The governance board shall implement the decategorization initiative in a manner that does not limit the legal rights of children and families to receive services.

153.13(5) Community service planning. The governance board shall undertake community planning activities within the county or counties comprising the project. These activities shall be designed to develop services that are more preventive, family-centered, and community-based.

a. As part of decategorization community planning, the governance board shall partner with other community stakeholders to develop service alternatives that provide less restrictive levels of care for children and families within the project area. The governance board shall involve community representatives, including representatives for families and youth and for county organizations, in the development of specific and quantifiable short-term and long-term plans for:

(1) Enhancing preventive, family-centered, and community-based services; and

(2) Reducing reliance on out-of-community care and restrictive interventions.

b. In community planning, the governance board may use information from federal reviews of Iowa's child welfare system and indicators and outcomes from other community planning efforts. The governance board shall coordinate its community planning efforts as much as possible with those of other planning entities in the community, such as but not limited to:

(1) Communities of promise;

(2) Community empowerment;

(3) United Way;

(4) Community partnerships for protecting children;

(5) Comprehensive school improvement planning;

(6) Comprehensive substance abuse agency planning; and

(7) Substance-abuse-free environment (SAFE) program planning.

153.13(6) *Annual service plan.* The governance board shall oversee the development and submission of an annual child welfare and juvenile justice services plan that meets the requirements of rule 441—153.18(232). The governance board shall involve community representatives and county organizations in the development of the plan for the use of the decategorization services funding pool.

153.13(7) *Fiscal management.* The governance board shall manage and have authority over the project's decategorization services funding pool.

a. The governance board shall develop a plan to maintain budget accountability by ensuring during each state fiscal year that there is ongoing accountability for results, fiscal monitoring, and oversight of expenditures from the decategorization services funding pool.

b. Budget planning and decategorization services funding decisions shall be coordinated with the affected service area managers and chief juvenile court officers or their designees throughout each state fiscal year.

c. The governance board shall ensure that expenditures do not exceed the amount of funding available within the funding pool.

d. If necessary, the governance board shall approve actions to reduce expenditures, discontinue programs, or take other action to manage expenditures within the available decategorization services funding pool during each state fiscal year.

153.13(8) *Annual report.* The governance board shall oversee the development and submission of an annual progress report for the decategorization project that meets the requirements of rule 441—153.19(232).

441—153.14(232) *Realignment of decategorization project boundaries.* If a governance board votes to change the composition of counties participating in the project, the governance board shall send a letter to the department director that describes the nature of the proposed project realignment and is signed by each board member who supports the proposed realignment.

153.14(1) If the realignment request involves the move of one or more counties from one decategorization project to another, the governance board of the project receiving the county or counties shall send a letter to the department director expressing support for the realignment.

153.14(2) The department director shall review the request and within 30 days shall provide a written decision to the project governance boards involved.

a. In evaluating the request, the department director shall consider the reasons expressed for the proposed realignment and the community and budgetary impacts of the realignment.

b. The director may consult with governance board representatives and others before making a decision.

441—153.15(232) *Decategorization services funding pool.*

153.15(1) *Creation and composition of pool.* The department shall create the decategorization services funding pool for a project by combining funding resources that may be made available to the project from one or more of the following funding sources:

a. The project's allocation of any funding designated for decategorization in a state appropriation. When the general assembly designates a portion of the department's child welfare appropriation specifically for decategorization services, the designated funds shall be allocated to decategorization project services funding pools. Unless otherwise specified by legislation, the designated funds shall be allocated among decategorization projects based solely on each project's share of the population of children under the age of 18.

b. Child welfare and juvenile justice services funds that are:

(1) Specifically designated and committed in writing to the project by the service area manager; and

(2) Accepted by the project's governance board.

c. Any juvenile justice program funds that are:

(1) Specifically designated and committed in writing to the decategorization project by a chief juvenile court officer; and

(2) Accepted by the project's governance board.

d. Any carryover funds available to the project from funding transfers and from operation of decategorization services during the previous state fiscal year.

e. Funds made available to the project from any other funding source, such as another state agency or a grant awarded to the project. Funds awarded to the project under this provision may be subject to specific conditions, reporting requirements, and expenditure limits specified by the entity that awards funding.

153.15(2) *Use of funding pool.* A governance board shall use the funding pool in accordance with the following requirements:

a. The funding pool shall be used to provide services that meet at least one of the following criteria:

(1) Services are flexible;

(2) Services are individualized;

(3) Services are family-centered;

(4) Services are preventive;

(5) Services are community-based;

(6) Services are comprehensive; or

(7) Services promote coordinated service systems for children and families in order to reduce the use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

b. The governance board may use the funding pool for enhancements to the child welfare and juvenile justice service systems within the project.

c. The funding pool shall not be used for any of the following services:

(1) Institutional services;

(2) Out-of-home services; or

(3) Out-of-community services.

d. The funding pool shall be expended in accordance with statutes and rules regarding vendor solicitation and service contracting, including Iowa Code chapter 8 and department of administrative services rules at 11—Chapters 106 and 107, Iowa Administrative Code.

153.15(3) *Designation and transfer of department funds.* A service area manager may choose during each state fiscal year to designate and transfer a portion of the service area's child welfare and juvenile justice service allocation to a decategorization project's funding pool. When designating funds, the service area manager and the governance board shall follow these procedures:

a. The service area manager shall provide written notification of any funding designations to the governance boards within the service area by June 1 of the state fiscal year. The service area manager shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of designated funding and provide written notification of acceptance or rejection to the service area manager by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(4) *Designation and transfer of juvenile justice funds.* A chief juvenile court officer may choose to designate and transfer a portion of the judicial district's juvenile justice program funding to a decategorization project's services funding pool. When designating funds, the chief juvenile court officer and the governance board shall follow these procedures:

a. The chief juvenile court officer shall provide written notification of any funding designations to the governance boards within the judicial district by June 1 of the state fiscal year. The chief juvenile

court officer shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of funding and shall provide the chief juvenile court officer with written notification of acceptance or rejection of the funding by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(5) Carryover funding. Funds allocated to a decategorization project from a legislative appropriation for decategorization services and funds designated and transferred to a decategorization project's funding pool that remain unencumbered or unobligated at the close of a state fiscal year are referred to as "carryover funding." The following procedures shall apply to the determination and use of decategorization carryover funding:

a. Upon the close of a state fiscal year, the department shall determine the exact amount of funding that is unencumbered or unobligated in each project's decategorization services funding pool. The department shall collaborate with governance boards to reconcile expenditure records and determine the amount of carryover funding for each decategorization project.

b. Before December 15 of each state fiscal year, the department shall provide each governance board with written notification of the official amount of carryover funding available from the previous state fiscal year.

c. Carryover funding shall not revert to the state general fund but shall remain available to the governance board until the close of the succeeding state fiscal year.

d. Carryover funding shall be under the authority of the project's governance board. These funds shall be available for expenditure for child welfare and juvenile justice systems enhancements and other purposes of the project as determined by the governance board.

e. Any carryover funding not expended by a decategorization project by the close of the succeeding state fiscal year shall revert to the fiscal authority of the department. The department shall return these funds to the state general fund.

441—153.16(232) Relationship of decategorization funding pool to other department child welfare funding. With the exception of any portion of the service area's child welfare allocation that is allocated by law for decategorization services, each service area's child welfare allocation shall be managed under the authority of the respective service area manager as follows:

153.16(1) Allocation. Each service area manager receives an allocation from the state appropriation for child welfare and juvenile justice services funding to meet child welfare and juvenile justice needs within all counties comprising the service area. The service area manager is responsible for meeting service needs throughout the service area within that allocation.

153.16(2) Budgeting. The service area manager may establish internal child welfare and juvenile justice services budget targets for the counties comprising the service area. Based on budget monitoring and changes in circumstances, the service area manager may revise the child welfare and juvenile justice budget targets within the service area to provide for the safety, permanency, and well-being of children served in the child welfare and juvenile justice systems.

153.16(3) Transfer to project. A service area manager may choose to designate and to transfer a portion of the service area's child welfare allocation to the funding pool of a decategorization project. The service area manager may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.16(4) *Communication with the governance board.* The service area manager shall regularly communicate with the governance boards within the service area to provide updated data and other information on child welfare and juvenile justice funding amounts, service expenditures and trends, and other issues in order to assist the governance board in service and budget planning.

441—153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams. Funds allocated by the department among the eight judicial districts for the court-ordered services and graduated sanctions programs shall be managed under the authority of the chief juvenile court officer for each judicial district as follows:

153.17(1) *Allocation.* Each chief juvenile court officer receives an allocation from the state appropriation for the court-ordered services and graduated sanction programs. The chief juvenile court officer is responsible for managing needs for these programs throughout the judicial district within that allocation.

153.17(2) *Budgeting.* The chief juvenile court officer may establish internal budget targets for expenditures from the court-ordered services and graduated sanction programs for the counties comprising the judicial district. Based on budget monitoring and changes in circumstances, a chief juvenile court officer may revise the budget targets established within the judicial district to provide programs most effectively for children within the district.

153.17(3) *Transfer to project.* A chief juvenile court officer may choose to designate and to transfer a portion of the judicial district's allocation for court-ordered services and graduated sanction programs to the funding pool of a decategorization project. The chief juvenile court officer may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.17(4) *Communication with the governance board.* The chief juvenile court officer shall regularly communicate with the governance boards within the judicial district to provide data and other information on juvenile justice program allocation amounts, service expenditures and trends, and other issues that may assist the governance boards in service and budget planning.

441—153.18(232) Requirements for annual services plan. Each decategorization project shall annually develop and submit a child welfare and juvenile justice decategorization services plan.

153.18(1) *Content of plan.* The decategorization services plan shall describe:

a. The project's proposed use of funding from the decategorization services funding pool during the state fiscal year.

b. The community planning and needs assessment process that was used in developing the annual decategorization services plan, including information on:

- (1) The community members and organizations that participated in developing the plan; and
- (2) Efforts to coordinate with other community planning initiatives affecting children and families.

c. The project's specific and quantifiable short-term plans and desired results for the state fiscal year and how these plans align with the project's long-term plans to improve outcomes for vulnerable children and families by enhancing service systems.

d. The methods that the project will use to track results and outcomes during the year.

e. The project's plans for monitoring and maintaining fiscal accountability, which shall include monitoring:

- (1) The performance and results achieved by contractors that receive funding; and
- (2) Expenditures from the decategorization services funding pool throughout the state fiscal year.

f. The project's plans to expend projected carryover funds by the conclusion of the state fiscal year.

153.18(2) *Submission of plan.* The decategorization services plan shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by October 1 of each state fiscal year.

441—153.19(232) Requirements for annual progress report. Each decategorization project shall develop and submit an annual progress report.

153.19(1) Content of report. At a minimum, the progress report shall:

- a. Summarize the project's key activities and the progress toward reaching the project's desired outcomes during the previous state fiscal year.
- b. Describe key activities, outcomes, and expenditures for programs and services that received funding from the governance board during the previous state fiscal year.
- c. Describe any lessons learned and planning adjustments made by the governance board during the previous state fiscal year.

153.19(2) Submission of report. The progress report shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by December 1 of each state fiscal year.

These rules are intended to implement Iowa Code Supplement section 232.188.

441—153.20 to 153.30 Reserved.

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES
[Rescinded IAB 3/6/02, effective 5/1/02]

441—153.31 to 153.50 Reserved.

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

PREAMBLE

The state payment program provides 100 percent state funds to pay for local mental health, mental retardation, and developmental disabilities services for eligible adults who have no legal settlement in Iowa. The state payment program is intended to enable all eligible residents to receive services from the county mental health, mental retardation and developmental disabilities services fund through the county central point of coordination, regardless of the resident's legal settlement status.

Three basic principles underlie the state payment program.

First, duration of residency, including legal settlement, is not an eligibility factor for local mental health, mental retardation, and developmental disabilities service programs. The state payment program ensures that each of the local mental health, mental retardation, and developmental disabilities services provided by an Iowa county to residents who have legal settlement is also available to residents of that county who do not have legal settlement.

Second, each state is responsible to provide care and services for its own residents. Iowa provides for residents of Iowa.

Third, one's own family is of primary importance to one's well-being. Thus, the state payment program emphasizes that care and services for a person be provided near the person's own family, unless this is contraindicated or impossible to provide.

441—153.51(331) Definitions.

"Adult" means a person who is 18 years of age or older and is a United States citizen or a qualified alien as defined in 8 U.S.C. §1641.

"Applicant" means a person for whom payment is requested from the state payment program.

"Approved county management plan" means the county plan for mental health, mental retardation, and developmental disabilities services developed pursuant to Iowa Code section 331.439 that has been approved by the department's director.

"Central point of coordination" or *"CPC"* means the administrative entity designated by a county board of supervisors or by the boards of supervisors of a consortium of counties to act as the single entry point to the service system established under an approved county management plan.

“*County of residence*” means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good-faith intention of living permanently or for an indefinite period. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps. “County of residence” does not mean the county where the adult is present for the purpose of:

1. Attending a college or university; or
2. Receiving services in a hospital, a correctional facility, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility.

The county of residence may be transferred using procedures set forth in subrule 153.53(5).

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

“*Division*” means the division of mental health and disability services of the department of human services.

“*Homeless person*” means a person who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is one of the following:

1. A supervised publicly or privately operated shelter designed to provide temporary living accommodations.
2. An institution that provides a temporary residence for persons intended to be institutionalized.
3. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

“*Legal representative*” means a person recognized by law as standing in the place or representing the interests of another; for example, a guardian, conservator, custodian, parent of a minor, or the executor, administrator or next of kin of a deceased person.

“*Legal settlement*” is a legal status as defined in Iowa Code sections 252.16 and 252.17.

“*Member*” means a person authorized by the division to receive benefits from the state payment program.

“*Provider*” means a provider of mental health, mental retardation, or developmental disabilities services that has a valid contract for the service with a county to provide services under a county management plan.

“*Resident,*” for purposes of division IV of this chapter, means a person who is present in the state and who has established an ongoing presence with the declared, good-faith intention of living in Iowa permanently or for an indefinite period.

441—153.52(331) Eligibility requirements. To be eligible for the state payment program, an applicant must meet all of the following conditions.

153.52(1) *Adult status.* The applicant shall be an adult as defined in 441—153.51(331).

153.52(2) *Residency.* The applicant shall be a resident of Iowa, present in the state and without legal settlement in an Iowa county. The applicant shall not be in Iowa for purposes of a visit or vacation nor be traveling through the state to another destination at the time of application for services.

153.52(3) *Eligibility under county management plan.* The applicant shall meet the eligibility criteria established in the approved county management plan for the applicant’s county of residence.

153.52(4) *Payment source.* The applicant shall have no other political entity, organization, or other source responsible for provision of or payment for the needed services nor be eligible to have the service funded or provided at no additional cost to the state by another state-funded or federally funded facility or program. The department may, on a case-by-case basis, attempt collection from a legally responsible entity.

441—153.53(331) Application procedure.

153.53(1) *Initiation of application.* The county CPC or the CPC’s designee shall be responsible for applying for state payment program funding for any person who may be eligible and whose county of residence is that county.

a. When an applicant is awaiting discharge from a state mental health institute or state resource center, the facility’s social worker shall initiate the application and forward it to the CPC of the applicant’s

county of residence for completion. If the applicant has no clear county of residence, the application shall be forwarded to the county where the applicant intends to establish residency upon discharge. This county may be designated by the applicant's declaration.

b. Applications shall be made only with the knowledge and consent of the applicant or the applicant's legal representative.

153.53(2) Application requirements. The CPC or the CPC's designee shall complete the application, preferably in electronic format. A complete application shall include:

a. A funding request for the applicant showing the total monthly dollar amount needed for services;

b. A copy of a legal settlement worksheet that is completed in accordance with provisions of Iowa Code chapter 252 and other applicable laws and rulings of courts; and

c. The client profile report (or equivalent) from a CPC application that contains information necessary for the division to enter the member into the data system used for payment processing.

153.53(3) Application submission. The CPC or the CPC's designee shall submit the complete application as defined in subrule 153.53(2) to the division within 15 business days of the date the CPC or designee receives a completed and signed CPC application form containing a properly completed legal settlement worksheet.

153.53(4) Application date. The date of application is the date of the CPC application form, the date on court documents, or October 1, 2006, whichever is later. This date may be used as the effective date of eligibility when the complete application is received in the division within 60 business days of the CPC application date or the date on court documents.

153.53(5) Transfer of county of residence. The designated county of residence for an adult may be transferred when it seems more reasonable for the county in which the person is receiving services to assume management of the services.

a. Examples of situations where transfer may be reasonable include, but are not limited to:

(1) The person receiving services has been in a facility for more than a year; and the person no longer has any connection to the county of residence, such as relatives who live there, and, so far as anyone can tell, has no desire to return to the county of residence.

(2) The person receiving services was in the state and county of residence for such a short time before needing services that no real attachment was established in the county of residence.

(3) The person is a student attending a college or university but lives and works in the community 12 months per year.

b. If the county of residence desires a transfer and the county in which the person is receiving services agrees, the county accepting the transfer shall notify the department's state payment program manager. The new county of residence shall complete the application procedures, if necessary, and maintain responsibility for the person's case.

c. If the county of residence desires a transfer and the county in which the services are being received does not agree, the county of residence may appeal for resolution to the residency team established by the mental health, mental retardation, developmental disabilities, and brain injury commission. Either county may appeal the decision of the residency team using the procedures in 441—Chapter 7.

441—153.54(331) Eligibility determination.

153.54(1) Approval by county.

a. The CPC or the CPC's designee shall determine whether an applicant is eligible for services based on the eligibility guidelines contained in the approved county management plan for the applicant's county of residence.

b. The county shall apply any policies and procedures regarding waiting lists to state payment program applicants in the same manner as it applies them to persons who have legal settlement in that county.

153.54(2) Certification by the department. Within 15 business days after receipt of a complete application as specified in subrule 153.53(2), division staff shall certify the applicant's eligibility for the state payment program to the central point of coordination.

a. The applicant's legal settlement status shall be ascertained in accordance with Iowa Code sections 252.16 and 252.17 and with other applicable laws, rulings of courts and opinions of the Iowa attorney general.

b. The division shall institute a waiting list for state payment program clients if the appropriation becomes fully encumbered. The division shall promptly notify all counties if a waiting list is to be instituted because of a lack of state funding.

153.54(3) Effective date of eligibility.

a. An applicant's eligibility for state payment program funding shall be effective from the date of application.

b. A member shall remain eligible until:

(1) The member has not received services for 12 months; or

(2) The CPC in the county of residence notifies the state payment program manager that the member is no longer eligible.

153.54(4) Notification of eligibility decisions. The CPC or the CPC's designee shall notify the applicant or member of the following decisions in accordance with CPC requirements and procedures:

a. Certification of the applicant's eligibility.

b. A change in a member's services, including termination of service.

441—153.55(331) Eligible services. Services eligible for reimbursement under the state payment program are the services defined in the approved county management plan of the applicant's county of residence.

153.55(1) Purchased services.

a. Service management may be provided through a county CPC process during the period for which services are paid.

b. The county may pay for services as long as the member is eligible and the following criteria are met:

(1) The member is receiving a service that requires funding from the state payment program.

(2) The service is provided under the approved county management plan of the member's county of residence.

(3) The member's county of residence provides or pays for the service from the county mental health, mental retardation, and developmental disabilities services fund for persons who have legal settlement in the county.

(4) Service providers bill the other payment systems for which the member is eligible before billing the county of residence.

153.55(2) Excluded costs. The following costs are excluded from payment by the state payment program:

a. Services received before the effective date of eligibility.

b. The cost of local services that the member is eligible to have funded by private sources or by other state or federal programs or funds such as medical assistance program services or services provided in a state institution.

441—153.56(331) Program administration.

153.56(1) CPC responsibilities.

a. Financial participation on the part of the member shall be governed by the financial participation provisions of the approved county management plan of the member's county of residence.

b. The CPC or the CPC's designee shall submit to the division's state payment program manager by the fifth business day of each month a report on the eligible services paid for during the previous month. The report shall be submitted electronically and shall include the following data in each record:

(1) The calendar month and year in which the county made the payment.

- (2) The name of the county submitting the information.
- (3) The member's name.
- (4) The member's state identification number.
- (5) The member's identification number as assigned under subparagraph 153.56(2) "a"(2).
- (6) The member's diagnostic group code.
- (7) The provider's name.
- (8) The chart of accounts code for each service paid.
- (9) The number of units paid (if applicable).
- (10) The beginning date of each service for which the county paid.
- (11) The ending date of each service for which the county paid.
- (12) The dollar amount paid.

c. The CPC or the CPC's designee shall include payments made on behalf of members in the data warehouse annual reports required by 441—Chapter 25, Division IV.

153.56(2) Department responsibilities. As the sponsoring agency, the department shall be responsible for:

- a. Enrolling members as necessary to produce payment to the counties, including:
 - (1) Maintaining member information in the data system for payment;
 - (2) Notifying counties of the member identification number required for billing; and
 - (3) Closing data system files on members as directed by the counties, or when the member has not had any payments processed for a 12-month period.
- b. Verifying receipt of monthly payment report files. Within 15 business days of receipt of each county's monthly payment report file, the department shall:
 - (1) Identify the county's payment amount for that month and the number of clients included in the payment; and
 - (2) Notify the county of any clients whose costs were denied and the reason for the denial.
- c. Generating and reconciling payments to the counties.
- d. Receiving and auditing reports of member activity and expenditures from the counties.

153.56(3) Payment to counties. The following policies shall govern payment to counties for services furnished to members:

- a. *Monthly payment.* Beginning in May 2007, the department shall make a monthly payment to each county based on the expense report for the previous month that was submitted by the county pursuant to paragraph 153.56(1) "b." The department shall process monthly payments by the twentieth day of each month.
- b. *Prospective payment.* The department may make a prospective payment to the county for cash flow purposes by July 10 of each year.
 - (1) The prospective payment shall be based on the sum of the expense reports that the department received from the county in April, May, and June of that year.
 - (2) For the state fiscal year ending June 30, 2007, the payments made to the county on or before April 1, 2007, shall be considered the prospective payment.
- c. *Payment reconciliation.* The department and counties shall reconcile the total of the prospective payment and monthly payments made to a county with the total actual expenses paid by the county for that same period.
- d. *Payment adjustment.* Beginning in April of each year, the department may adjust the monthly payment to the county to:
 - (1) Spend down the balance of the prospective payments previously made; or
 - (2) Make additional payment to ensure that the county has sufficient moneys for cash flow purposes.
- e. *Deductions.* For the state fiscal year ending June 30, 2007, moneys that the county received but did not expend, according to the report required by paragraph 153.56(1) "b," shall be deducted from the county's subsequent payment.

441—153.57(331) Reduction, denial, or termination of benefits. The member's state payment program benefits may be denied, terminated or reduced according to the provisions of the approved county management plan of the member's county of residence.

441—153.58(331) Appeals.

153.58(1) Decisions regarding eligibility of any applicant, decisions regarding instituting a waiting list because the appropriation has been fully encumbered, and decisions adversely affecting applicants or members who are not eligible may be appealed pursuant to 441—Chapter 7.

153.58(2) Decisions (other than eligibility) adversely affecting applicants or members shall be appealed pursuant to the county CPC's appeal provisions.

These rules are intended to implement Iowa Code section 331.440 as amended by 2006 Iowa Acts, chapter 1115, division III.

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TITLE XV
*INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES*
CHAPTER 170
CHILD CARE SERVICES
[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, a nonregistered family child care home, or in a facility exempt from licensing or registration.

441—170.1(237A) Definitions.

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

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

“Child care” means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

“Child with protective needs” means a child who has a case plan that identifies protective child care as a required service and who is a member of a family with one of the following:

1. A confirmed case of child abuse.
2. Episodes of family or domestic violence or substance abuse which place the child at risk of abuse or neglect and have resulted in a service referral to family preservation or family-centered services.

“Child with special needs” means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.
3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

“*Client*” means a current or former recipient of the child care assistance program.

“*Client error*” means and may result from:

1. False or misleading statements, oral or written, regarding the client’s income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

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

“*Food services*” means the preparation and serving of nutritionally balanced meals and snacks.

“*Fraudulent means*” means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

“*In-home*” means care which is provided within the child’s own home.

“*Migrant seasonal farm worker*” means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person’s permanent residence within the same day.
2. Most of the person’s income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.
3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

“*Overpayment*” means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

“*Parent*” means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

“*Program and activities*” means the daily schedule of experiences in a child care setting.

“*PROMISE JOBS*” means the department’s training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93, Division II.

“*Provider*” means a licensed child care center, a registered child development home, a relative who provides care in the relative’s own home solely for a related child, a caretaker who provides care for a child in the child’s home, a nonregistered child care home, or a child care facility which is exempt from licensing or registration.

“*Provider error*” means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

“*Recoupment*” means the repayment of an overpayment by a payment from the client or provider or both.

“*Relative*” means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

“*Supervision*” means the care, protection, and guidance of a child.

“*Transportation*” means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

“*Unit of service*” means a half day which shall be up to 5 hours of service per 24-hour period.

“*Vocational training or education*” means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

1. Training may be approved for high school completion activities, adult basic education, GED, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

2. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time plans may be approved only if the number of credit hours to complete training is less than full-time status, the required prerequisite credits or remedial course work is less than full-time status, or training is not offered on a full-time basis.

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) Financial eligibility. Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa’s median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. Income limits. For initial and ongoing eligibility, a family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” cannot exceed:

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa’s median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. Exceptions to income limits.

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. Determining gross income. In determining a family’s gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)“d.”

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers’ compensation, alimony, child support, and veterans pensions. “Net profit from self-employment” means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

d. Income exclusions. The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food Stamp Act of 1964.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under Title III, Part C—Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973.

(18) Stipends received for participating in the foster grandparent program.

(19) The first \$65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

(28) Federal or state earned income tax credit.

(29) Payments from the Iowa individual assistance grant program (IIAGP).

(30) Payments from the transition to independence program (TIP).

(31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

(32) Reimbursement from the employer for job-related expenses.

(33) Stipends from the preparation for adult living (PAL) program.

(34) Payments from the subsidized guardianship waiver program.

(35) The earnings of a child aged 18 or under who is a full-time student.

(36) Census earnings received by temporary workers from the Bureau of the Census.

e. Family size. The following people shall be included in the family size for the determination of eligibility:

- (1) Legal spouses (including common law) who reside in the same household.
- (2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.
- (3) A child or children who live with a person or persons not legally responsible for the child's support.

f. Effect of temporary absence. The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

- (1) An absence for the purpose of education or employment.
- (2) An absence due to medical reasons that is anticipated to last less than three months.
- (3) Any absence when the person intends to return home within three months.

170.2(2) General eligibility requirements. In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

a. Age. Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19.

b. Need for service. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit.

Payment shall not be approved for the following:

1. When labor market statistics for a local area indicate low employment potential. Exceptions may be made when the client has a job offer prior to entering the training or if a client is willing to relocate after training to an area where there is employment potential. Clients willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the client.

2. Jobs paying less than minimum wage.

3. College coursework for a client who possesses a baccalaureate degree unless the coursework is to obtain a teaching certificate or complete continuing education units.

4. The course or training is one that the client has previously completed.

5. When the client was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.

PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment of a single parent or the coinciding hours of employment of both parents in a two-parent home and for actual travel time between home, child care facility, and place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent needs child care as part of a protective service plan to prevent or alleviate child abuse or neglect.

(4) The person who normally cares for the child is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but is unable to care for the child, as verified by a physician. Care under this paragraph is limited to a maximum of

one month, unless extenuating circumstances are justified and approved after case review by the service area manager or designee.

(5) The parent is looking for employment. Child care for job search shall be limited to only those hours the parent is actually looking for employment including travel time. A job search plan shall be approved by the department and limited to a maximum of 30 working days in a 12-month period. Child care in two-parent families may be provided only during the coinciding hours of both parents' looking for employment, or during one parent's employment and one parent's looking for employment. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

EXCEPTION: Additional hours may be paid for job search for PROMISE JOBS recipients if approved by the PROMISE JOBS worker.

(6) The person is participating in activities approved under the PROMISE JOBS program and there is a need for child care services.

(7) The family is part of the family investment program and there is a need for child care.

If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

c. Residency. To be eligible for child care services, the person must be living in the state of Iowa. "Living in the state" shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

d. Citizenship. As a condition of eligibility, the applicant shall attest to the child's citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0466, Health and Financial Support Application. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child's entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or

2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

e. Cooperation. Parents shall cooperate with the department when the department selects the family's case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

170.2(3) Priority for assistance. Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of

the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2) "b" except at review or redetermination.

170.2(4) Reporting changes. The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported, the effective date of the change shall be the date when the change is reported to the department office or PROMISE JOBS office.

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) Application process.

a. Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application, or

(2) Form 470-0462 or 470-0466, Health and Financial Support Application.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received in the department office.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of no longer than six months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

170.3(2) Exceptions to application requirement. Applications are not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

c. Families with protective service needs.

d. Child care services provided under a court order.

170.3(3) Application processing. The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility. EXCEPTION: When the court orders services, the court order provided by the court and the case plan provided by the department shall serve as written notification.

170.3(4) *Waiting lists for child care services.* When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* The department shall redetermine a family's financial and general eligibility for child care assistance at least every six months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP) and for those whose earned income was taken into account in determining the needs of FIP recipients, because these people are deemed financially eligible so long as the FIP eligibility continues.

a. If FIP eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility. The department shall issue a notice of expiration for the child care assistance certification period in Form 470-4377 or 470-4377(S). If the family does not return the review form to the department by the end of the certification period, the family must reapply for benefits.

441—170.4(237A) Elements of service provision.

170.4(1) *Case plan.* The case plan shall be developed by the department service worker and contain information described in 441—subrule 130.7(2), when the child meets the need for service under 170.2(2)“b”(3).

170.4(2) *Fees.* Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. *Sliding fee schedule.* The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2009:

Level	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
A	\$858	\$1,154	\$1,450	\$1,746	\$2,043	\$2,338	\$2,634	\$2,931	\$3,226	\$3,523	\$0.00	\$0.00	\$0.00
B	\$903	\$1,215	\$1,526	\$1,838	\$2,150	\$2,461	\$2,773	\$3,085	\$3,396	\$3,708	\$0.20	\$0.45	\$0.70
C	\$928	\$1,249	\$1,569	\$1,889	\$2,210	\$2,530	\$2,851	\$3,171	\$3,491	\$3,812	\$0.45	\$0.70	\$0.95
D	\$954	\$1,283	\$1,611	\$1,941	\$2,270	\$2,599	\$2,928	\$3,258	\$3,586	\$3,916	\$0.70	\$0.95	\$1.20
E	\$980	\$1,319	\$1,657	\$1,995	\$2,334	\$2,672	\$3,010	\$3,349	\$3,687	\$4,025	\$0.95	\$1.20	\$1.45

Level	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
F	\$1,007	\$1,355	\$1,702	\$2,050	\$2,398	\$2,744	\$3,092	\$3,440	\$3,787	\$4,135	\$1.20	\$1.45	\$1.70
G	\$1,035	\$1,393	\$1,749	\$2,107	\$2,465	\$2,821	\$3,179	\$3,537	\$3,893	\$4,251	\$1.45	\$1.70	\$1.95
H	\$1,063	\$1,431	\$1,797	\$2,164	\$2,532	\$2,898	\$3,265	\$3,633	\$3,999	\$4,366	\$1.70	\$1.95	\$2.20
I	\$1,093	\$1,471	\$1,847	\$2,225	\$2,603	\$2,979	\$3,357	\$3,735	\$4,111	\$4,489	\$1.95	\$2.20	\$2.45
J	\$1,123	\$1,511	\$1,898	\$2,286	\$2,674	\$3,060	\$3,448	\$3,836	\$4,223	\$4,611	\$2.20	\$2.45	\$2.70
K	\$1,154	\$1,553	\$1,951	\$2,350	\$2,748	\$3,146	\$3,545	\$3,944	\$4,341	\$4,740	\$2.45	\$2.70	\$2.95
L	\$1,186	\$1,595	\$2,004	\$2,414	\$2,823	\$3,232	\$3,641	\$4,051	\$4,460	\$4,869	\$2.70	\$2.95	\$3.20
M	\$1,219	\$1,640	\$2,060	\$2,481	\$2,902	\$3,322	\$3,743	\$4,166	\$4,584	\$5,006	\$2.95	\$3.20	\$3.45
N	\$1,252	\$1,685	\$2,116	\$2,549	\$2,981	\$3,413	\$3,845	\$4,278	\$4,709	\$5,142	\$3.20	\$3.45	\$3.70
O	\$1,287	\$1,732	\$2,175	\$2,620	\$3,065	\$3,508	\$3,953	\$4,398	\$4,841	\$5,286	\$3.45	\$3.70	\$3.95
P	\$1,322	\$1,779	\$2,235	\$2,691	\$3,148	\$3,604	\$4,061	\$4,518	\$4,973	\$5,430	\$3.70	\$3.95	\$4.20
Q	\$1,359	\$1,829	\$2,297	\$2,767	\$3,237	\$3,705	\$4,174	\$4,644	\$5,112	\$5,582	\$3.95	\$4.20	\$4.45
R	\$1,396	\$1,879	\$2,360	\$2,842	\$3,325	\$3,806	\$4,288	\$4,771	\$5,251	\$5,734	\$4.20	\$4.45	\$4.70
S	\$1,435	\$1,931	\$2,426	\$2,922	\$3,418	\$3,912	\$4,408	\$4,904	\$5,398	\$5,894	\$4.45	\$4.70	\$4.95
T	\$1,475	\$1,984	\$2,492	\$3,001	\$3,511	\$4,019	\$4,528	\$5,038	\$5,546	\$6,055	\$4.70	\$4.95	\$5.20
U	\$1,516	\$2,040	\$2,562	\$3,085	\$3,609	\$4,131	\$4,655	\$5,179	\$5,701	\$6,225	\$4.95	\$5.20	\$5.45
V	\$1,557	\$2,095	\$2,631	\$3,169	\$3,707	\$4,244	\$4,782	\$5,320	\$5,856	\$6,394	\$5.20	\$5.45	\$5.70
W	\$1,601	\$2,154	\$2,705	\$3,258	\$3,811	\$4,363	\$4,916	\$5,469	\$6,020	\$6,573	\$5.45	\$5.70	\$5.95
X	\$1,644	\$2,212	\$2,779	\$3,347	\$3,915	\$4,481	\$5,050	\$5,618	\$6,184	\$6,752	\$5.70	\$5.95	\$6.20
Y	\$1,690	\$2,274	\$2,857	\$3,441	\$4,025	\$4,607	\$5,191	\$5,775	\$6,357	\$6,941	\$5.95	\$6.20	\$6.45
Z	\$1,736	\$2,336	\$2,934	\$3,534	\$4,134	\$4,732	\$5,332	\$5,932	\$6,530	\$7,130	\$6.20	\$6.45	\$6.70
AA	\$1,785	\$2,402	\$3,017	\$3,633	\$4,250	\$4,865	\$5,482	\$6,098	\$6,713	\$7,330	\$6.45	\$6.70	\$6.95
BB	\$1,834	\$2,467	\$3,099	\$3,732	\$4,366	\$4,997	\$5,631	\$6,264	\$6,896	\$7,530	\$6.70	\$6.95	\$7.20

To use the chart:

- (1) Find the family size used in determining income eligibility for service.
- (2) Move across the monthly income table to the column headed by that number. (See subparagraph (5) if the family has more than ten members.)
- (3) Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.
- (4) Choose the fee that corresponds to the number of children in the family who receive child care assistance.
- (5) When a family has more than ten members, determine the income level by multiplying the figures in the four-member column for the rows closest to the family's income level by 0.03. Round the numbers to the nearest dollar and multiply by the number of family members in excess of ten. Add the results to the amounts in the ten-member column to determine the threshold amounts.

EXAMPLES:

1. Family 1 has two members, monthly income of \$1,100, and one child in care. Since the income is at or above the Level A amount but less than the Level B amount, Family 1 pays \$0.00 for each unit of child care service that the child receives.
2. Family 2 has three members, monthly income of \$1,450, and one child in care. Since the income is at or above the Level B amount but less than the Level C amount, Family 2 pays \$0.20 for each unit of child care service that the child receives.

3. Family 3 has three members, monthly income of \$1,450, and two children in care. The younger child receives ten units of child care service per week. The older child is school-aged and receives only five units of service per week. Since the income is at or above the Level B amount but less than the Level C amount, Family 3 pays \$0.45 for each unit of child care service that the younger child receives.

b. Collection. The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) Method of provision. Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)"b"(3), as long as the conditions in paragraph 170.4(7)"d" are met. When the child meets the need for service under 170.2(2)"b"(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. Registered family child care home. Rescinded IAB 1/7/04, effective 3/1/04.

d. Relative care. Rescinded IAB 2/6/02, effective 4/1/02.

e. In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form

470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

- (1) Minimum health and safety requirements;
- (2) Limits on the number of children for whom care may be provided;
- (3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and
- (4) Conditions that warrant nonpayment.

g. Exempt facilities. Child care facilities operated by or under contract to a public or nonpublic school accredited by the department of education that are exempt from licensing or registration may receive payment for child care services when selected by a parent.

h. Record checks for nonregistered family child care homes. If a nonregistered child care provider wishes to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form 470-0643, Request for Child Abuse Information, and Form 595-1489 or 595-1489(S), Non-Law Enforcement Record Check Request, Form A, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The department worker or the PROMISE JOBS worker shall provide the necessary forms. The provider shall return the forms to the department worker or PROMISE JOBS worker.

(1) If any of these individuals has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the department shall perform an evaluation following the process defined at 441—subrule 110.7(3).

(2) If any of the individuals would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant, and shall forward a copy of that notification to the county attorney, the department worker, and the PROMISE JOBS worker, if applicable.

(3) A person who continues to provide child care in violation of this law is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) Components of service program. Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) Levels of service according to age. Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) Provider's individual program plan. An individual program plan shall be developed by the child care provider for each child within 30 days after placement when the need for service was established under 170.2(2)"b"(3). The program plan shall be supportive of the service worker's case plan. The program plan shall contain goals, objectives, services to be provided, and time frames for review.

170.4(7) Payment. The department shall make payment for child care provided to eligible families when the provider has a completed Form 470-3871, Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker or PROMISE JOBS worker shall sign this form.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)"d," shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for "child with special needs," and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$15.81	\$12.24	\$11.73	\$8.19
Preschool	\$12.75	\$11.48	\$11.48	\$7.19
School Age	\$11.48	\$10.20	\$10.20	\$7.36

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	\$48.96	\$16.07	\$12.63	\$10.24
Preschool	\$28.69	\$14.92	\$12.63	\$ 8.99
School Age	\$28.60	\$13.77	\$11.48	\$ 9.20

The following definitions apply in the use of the rate tables:

(1) "Child care center" shall mean those providers as defined in 170.4(3) "a" and "g." "Registered child development home" shall mean those providers as defined in 170.4(3) "b." "Nonregistered family child care home" shall mean those providers as defined in 170.4(3) "f."

(2) Under age group, "infant and toddler" shall mean age two weeks to two years; "preschool" shall mean two years to school age; "school age" shall mean a child in attendance in full-day or half-day classes.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. Payment for multiple children in a family. When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. Limitations on payment. Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. Review of the calculation of the rate of payment. Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7) "a" may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

g. Submission of claims. The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay only for the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-0020, Purchase of Services Provider Invoice, or Form 470-4466 or 470-4466(S), Child Care Provider Claim, accompanied by Form 470-3872, Child Care Assistance Attendance Sheet, signed by the parent;

(2) Using Form 470-3896, PROMISE JOBS Child Care Attendance and Invoice;

(3) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(4) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[ARC 7837B, IAB 6/3/09, effective 7/1/09]

441—170.5(237A) Adverse actions.

170.5(1) Provider agreement. The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871, if:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazards; or

b. The provider has submitted claims for payment for which the provider is not entitled; or

c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

170.5(2) Denial. Child care assistance shall be denied when the department determines that:

a. The client is not in need of service; or

b. The client is not financially eligible; or

c. There is another community resource available to provide the service or a similar service free of charge; or

d. An application is required and the client or representative refuses or fails to sign the application form; or

e. Funding is not available; or

f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(3) Termination. Child care assistance may be terminated when the department determines that:

a. The client no longer meets the eligibility criteria in subrule 170.2(2); or

b. The client's income exceeds the financial guidelines; or

c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

e. Another community resource is available to provide the service or a similar service free of charge; or

f. Funding is not available; or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(4) Reduction. Authorized units of service may be reduced when the department determines that:

a. Continued provision of service at the current level is not necessary to meet the client's service needs; or

b. Another community resource is available to provide the same or similar service free of charge that will meet the client's needs; or

c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

[ARC 7740B, IAB 5/6/09, effective 6/10/09]

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) Fraud. The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000.

170.7(2) Potential sanctions. Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

a. Special review of the provider's claims for child care assistance.

b. Suspension from receipt of child care assistance payment for six months.

c. Ineligibility to receive payment under child care assistance.

170.7(3) Factors considered in determining level of sanction. The department shall evaluate the following factors in determining the sanction to be imposed:

a. History of prior violations.

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

b. Prior imposition of sanctions.

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

c. Seriousness of the violation.

(1) If the amount fraudulently received is less than \$5,000, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs “a” and “b” is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs “a” and “b” is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

d. Extent of the violation.

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs “a” and “b.”

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs “a” and “b” is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs “a” and “b” is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

170.7(4) Mitigating factors.

a. If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

- (1) Prior provision of provider education.
- (2) Provider willingness to obey program rules.

b. If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph “a” indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

- (1) Suspension from receipt of child care assistance payment for six months; and
- (2) A special review of provider claims.

c. If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph “a” indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

441—170.8(234) Allocation of funds. Rescinded IAB 2/6/02, effective 4/1/02.

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments shall be subject to recoupment.

170.9(1) Notification and appeals. All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client’s or provider’s request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—subrule 7.5(9).

170.9(2) Determination of overpayments. All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

170.9(3) Benefits or payments issued pending appeal decision. Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

170.9(4) Failure to cooperate. Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

170.9(5) *Payment agreement.* The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

170.9(6) *Procedures for recoupment.*

a. When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment using one of the following forms:

- (1) Form 470-3627, Demand Letter for Child Care Assistance Provider Error Overissuance; or
- (2) Form 470-3628, Demand Letter for Child Care Assistance Agency Error Overissuance;
- (3) Form 470-3807, Demand Letter for Child Care Assistance Client Error Benefit Overissuance;

or

- (4) Form 470-4530, Notice of Child Care Assistance Overpayment.

c. When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

170.9(7) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than \$35. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

These rules are intended to implement Iowa Code sections 237A.13 and 237A.29.

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NATURAL RESOURCES DEPARTMENT[561]

Created by 1986 Iowa Acts, chapter 1245, section 1802

Rules of divisions under this Department "umbrella" include Energy and Geological Resources[565], Environmental Protection Commission[567], Natural Resource Commission[571], and Preserves, State Advisory Board[575]

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CHAPTER 12
SPECIAL NONRESIDENT DEER AND TURKEY LICENSES

561—12.1(483A) Purpose. These rules establish the process by which the department will issue special nonresident deer and turkey licenses to individuals as part of statewide or local efforts to promote the state and its natural resources.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.2(483A) Definitions. When used in this chapter:

“Conservation organization” means an organization that is developed and managed pursuant to Iowa Code chapter 504, the revised Iowa nonprofit corporation Act, and whose mission emphasizes natural resource conservation or supports science-based natural resource management. A local or state chapter or division of a national or international conservation organization shall qualify as a conservation organization.

“Coordinator” means the department staff person appointed by the director to administer the process for allocation of special nonresident deer and turkey licenses pursuant to this chapter.

“Department” means the department of natural resources.

“Director” means the director of the department of natural resources.

“Internal committee” means the committee that ranks certain requests for special licenses for consideration by the legislative committee and consists of the coordinator, the administrator of the conservation and recreation division, the chief of the wildlife bureau, and the chief of the law enforcement bureau.

“Legislative committee” means the committee that makes the final selection of recipients of special nonresident deer and turkey licenses and consists of the majority leader of the Iowa senate, the speaker of the Iowa house of representatives, and the director of the Iowa department of economic development, or their designees, as described in Iowa Code section 483A.24.

“Outdoor industry” means a commercial enterprise or venture that promotes or otherwise contributes to the use of natural resources. For purposes of illustration, an outdoor industry may include, but is not limited to, a television or radio show production; a video/DVD production; still and motion photography; an article in the popular print media, such as in a newspaper or periodical; a lecture presentation; the manufacture or acquisition of sporting equipment for resale; or a similar activity. A business that solely provides guide or outfitter services is not an outdoor industry.

“Program” means the review and selection process through which special nonresident deer and turkey licenses are allocated in accordance with Iowa Code section 483A.24 and these rules.

“Special licenses” means the special nonresident deer licenses and special nonresident turkey licenses issued pursuant to these rules.

“Special nonresident deer license” means a deer license issued pursuant to Iowa Code section 483A.24(3).

“Special nonresident turkey license” means a turkey license issued pursuant to Iowa Code section 483A.24(4).

“Sponsor” means an entity that applies on behalf of one or more hunters.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.3(483A) Availability of special licenses. The program shall be available to provide not more than the number of special licenses allowed by Iowa Code section 483A.24 to nonresidents through requests submitted by individual hunters or through a sponsor. Sponsors may be located in the state of Iowa.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.4(483A) Coordinator duties. The coordinator of the program shall:

12.4(1) Assist the internal and legislative committees in the evaluation and selection of hunters who may receive special licenses.

12.4(2) Develop templates for requests for special licenses and provide the templates to hunters and sponsors upon request.

12.4(3) Convene the internal committee to rank hunters according to the criteria in rule 561—12.7(483A).

12.4(4) Summarize each request received and distribute the summaries to the internal committee and legislative committee.

12.4(5) Provide additional information regarding requesters as needed to aid the legislative committee in the selection process.

12.4(6) Establish the dates on which the legislative committee will select the conservation organizations and hunters who will receive special licenses and inform the organizations and hunters of their selection.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.5(483A) Request, review and selection process.

12.5(1) *Submission of requests.* Individual hunters or sponsors shall submit a request, or requests, to the coordinator. A request must be on the form provided by the department and may be submitted to the coordinator at any time during the year.

12.5(2) *Review.*

a. The internal committee shall review the summaries prepared by the coordinator, rank the hunters according to criteria in rule 561—12.7(483A), and forward the rankings to the legislative committee for consideration and final selection.

b. Requests that demonstrate little or no promotion of the state of Iowa or its natural resources, as determined by the internal committee, shall not be included in the rankings forwarded to or considered by the legislative committee.

c. Review of requests shall occur at least once annually but may occur more frequently as needed based upon the number of requests and the dates by which they are received.

12.5(3) *Selection and payment.* Upon notice of selection to receive a special license, the sponsor or hunter shall make payment in accordance with rule 561—12.12(483A) to the department through the coordinator. Payment must be made at least 30 days prior to the hunting season for which the license is valid.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.6(483A) Consideration of requests. The legislative committee will determine which conservation organizations and hunters are best qualified to promote the state and its natural resources. In making such a determination, the legislative committee will select hunters and conservation organizations based on their expected ability to promote the state and its natural resources and, if applicable, based on the degree of success special license holders have had in previous years or seasons in promoting the state and its natural resources. By way of illustration, the committee may consider requests from the following:

12.6(1) A hunter who has a direct beneficial impact on the state through an arm's-length business relationship with an Iowa-based outdoor industry.

12.6(2) A conservation organization that will use the special nonresident deer license as a fund-raiser for that organization. A conservation organization shall be limited to one special nonresident deer license per year, whether the organization is a local or state chapter or division of a national or international conservation organization. The organization shall return to the department the greater amount of either one-half of the proceeds from its sale of the special nonresident deer license or the fee for a nonresident deer license as set forth in Iowa Code section 483A.1. The department's proceeds shall cover the cost of the special nonresident deer license. A license made available to a conservation organization in accordance with this subrule may be valid for up to two years after selection of the organization by the legislative committee. The sponsoring conservation organization shall notify the coordinator by July 1 or immediately following the sale of the special nonresident deer license of which year and for what season the special nonresident deer license will be used. The conservation organization shall specifically explain

how and during what period the organization will market the special nonresident deer license for auction or some other legal fund-raiser.

12.6(3) A hunter nominated by the governor, a member of the Iowa legislature or a member of the legislative committee.

12.6(4) A hunter recommended by the department.

12.6(5) A hunter who is a well-known public figure nationally or regionally and who may provide a positive portrayal of the state and its natural resources.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.7(483A) Ranking criteria.

12.7(1) The following criteria shall be used by the internal committee to rank individual hunters as identified in subrules 12.6(1), 12.6(4) and 12.6(5). The rankings shall be determined as the average of the following rating points and will be provided to the legislative committee as an aid in determining the selection of hunters.

- a. Ten points if the hunter is directly affiliated with an Iowa-based outdoor industry.
- b. From 0 to 10 points applied to each of the following:
 - (1) The relative size of the hunter's potential audience.
 - (2) The hunter's proposal to promote the state and its natural resources.
 - (3) If the hunter has received a special license in the past, the value of the actual promotion of the state and its natural resources or special services provided as a result.
- c. From 0 to 5 points if the hunter meets the description in subrule 12.6(5).

12.7(2) A conservation organization's request shall be forwarded to the legislative committee if the conservation organization meets the definition in rule 561—12.2(483A) and based on an evaluation of the organization's prior performance, if any, in selling the special nonresident deer license.

12.7(3) Hunters as identified in subrule 12.6(3) shall not be ranked by the internal committee, and their requests will be forwarded to the legislative committee for its determination.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.8(483A) Services provided by recipients of special licenses. In addition to promoting the state and its natural resources, recipients of special licenses may improve the ranking they receive for future license requests by providing additional services as specified by the department. Services shall be limited to services which improve communications between the department and outdoor recreationalists and to assistance in marketing outdoor recreation and natural resource conservation.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.9(483A) License term. With the exception of the term provided for in subrule 12.6(2), special licenses issued under these rules shall be valid for only the applicable deer or turkey season immediately following allocation of the license.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.10(483A) Reporting. Within eight months after a hunter's participation in a hunt with a license issued pursuant to this chapter, the sponsor or hunter shall provide to the coordinator information about the hunt to demonstrate how the hunt will provide or has provided promotion of the state and its natural resources. This information may be in the form of testimonials of the participants, a completed DVD available for retail sale, a DVD copy of the actual television broadcast, an article in a periodical, or other verifiable means that demonstrate the promotional benefits. The legislative committee may consider compliance with this reporting requirement in evaluating future requests.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.11(483A) Prohibitions. Photographs, videotapes, or any other form of media resulting from the special licenses issued pursuant to this chapter shall not be used for political campaign purposes.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.12(483A) License costs. With the exception provided in subrule 12.6(2) for conservation organizations, a nonresident who obtains a special license issued pursuant to this chapter shall pay the applicable fee as follows:

12.12(1) For a special nonresident deer license, the fee described in Iowa Code section 483A.1 for a deer hunting license, antlered or any sex deer.

12.12(2) For a special nonresident turkey license, the fee described in Iowa Code section 483A.1 for a wild turkey hunting license.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.13(483A) Hunter safety requirements. As provided in Iowa Code sections 483A.24(3) and 483A.24(4), the hunter safety and ethics certificate requirement is waived for holders of special licenses issued pursuant to this chapter.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 483A.24.

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641—15.1(135I) Applicability.

15.1(1) These rules apply to swimming pools, spas, wading pools, water slides, wave pools, spray pads, and bathhouses connected to swimming pools owned or operated by local or state government, or commercial interests or private entities including, but not limited to, public or private school corporations, hotels, motels, camps, apartments, condominiums, health clubs and country clubs. These rules do not apply to a residential swimming pool or spa that is permanently installed in a single-family dwelling, to a decorative fountain, or to a therapeutic swimming pool or spa which is under the direct supervision of qualified medical personnel.

15.1(2) These rules do not apply to a swimming pool or spa operated by a homeowners association representing 72 or fewer dwelling units if the association bylaws, which also apply to a rental agreement relative to any of the dwelling units, include an exemption from the requirements of this chapter, provide for inspection of the swimming pool or spa by an entity other than the department or a local inspection agency, and assume any liability associated with operation of the swimming pool and spa. The association shall notify the department in writing if the association bylaws are amended as above. The inspector designated by the association shall be a certified operator as defined in 15.3(1). A report of the inspection shall be filed with the association secretary and shall be available to any association member on request.

641—15.2(135I) Scope. These rules stipulate minimum safety and water quality requirements for the operation of swimming pools and spas; standards for construction; procedures for registration; qualifications for swimming pool and spa inspectors; qualifications for swimming pool and spa operators and lifeguards; and procedures for health departments to provide for the inspection of swimming pools and spas and enforcement of these rules. Swimming pools and spas which are in compliance with these rules must also comply with the requirements of any other applicable federal, state or local laws, rules or ordinances.

641—15.3(135I) Definitions and abbreviations.

15.3(1) Definitions.

“Air break” is a piping arrangement in which a drain from a fixture, appliance or device discharges indirectly into a fixture, receptacle, or interceptor at a point below the flood-level rim of the receptacle.

“Air gap” means the unobstructed vertical distance through the free atmosphere between the lowest opening from an inlet pipe and the flood-level rim of a receptacle or floor drain.

“Board of health” means a county, city, or district board of health.

“Body feed” means the continuous addition of controlled amounts of filtering aid during the operation of a diatomaceous earth filter to maintain a permeable filter cake. This is sometimes referred to as a “slurry feed.”

“Certified operator” means a person who has:

1. Successfully completed the Certified Pool/Spa Operator[®] course sanctioned by NSPF, the Aquatic Facility Operator course sanctioned by NRPA, the Professional Pool & Spa Operator course sanctioned by the APSP, the Licensed Aquatic Facility Technician course sanctioned by the American Swimming Pool and Spa Association, or an equivalent course approved by the department; and
2. Been recertified as required by the sanctioning organization; and
3. Obtained the continuing education required by 15.11(2).

“Combined chlorine” means nitrogen-chlorine compounds formed by the reaction of a chlorine disinfectant chemical with ammonia and organic nitrogen compounds as measured with a DPD (diethyl-p-phenylene diamine) test kit or as measured by another method approved by the department. Another term for combined chlorine is “chloramines.”

“*Construction*” means the installation of a new swimming pool facility. “Construction” includes modifications to an existing facility which change the total recirculated water volume or the total water surface area by 20 percent or more.

“*Deck*” means a walkway immediately adjacent to a swimming pool.

“*Decorative fountain*” means a basin equipped with water sprays or jets that does not serve primarily as a wading or swimming pool and whose drain is not directly connected to any type of suction device for removing or recirculating the water.

“*Deep water*” means those areas of a swimming pool where the water is more than five feet deep.

“*Department*” means the Iowa department of public health.

“*Di-chlor*” means sodium dichloro-s-triazinetriene dihydrate. Di-chlor is a form of chlorine that includes cyanuric acid in its formulation.

“*Engineering plans*” means plans and specifications certified in accordance with the rules of the engineering and land surveying examining board or the architectural examining board by an engineer or architect licensed to practice in the state of Iowa.

“*Equalizer*” means an arrangement including a pipe from an opening below the water level in a swimming pool or spa to the body of a skimmer and a normally closed valve at the skimmer body. The arrangement is designed to automatically prevent air from being drawn into the pump when the water level drops below the skimmer inlet. The equalizer opening in a swimming pool or spa is a fully submerged outlet.

“*Facility*” means a building, fenced enclosure, or lot where there is at least one swimming pool or spa subject to regulation under Iowa Code chapter 135I and these rules.

“*Field fabricated,*” when applied to a sump or a cover/grate for a fully submerged outlet, means constructed on site with conventional building materials or of a size and shape different from readily available commercial sumps or cover/grates.

“*Fill and drain wading pool*” means a wading pool having no recirculation system.

“*Filter*” means a mechanical device for removing suspended particles from the swimming pool water and refers to the complete mechanism including all component parts.

“*Flow rating,*” when applied to the cover/grate for a fully submerged outlet, means the maximum flow rate in gpm through the cover/grate that will not cause body or hair entrapment as determined by the test methods in the ASME standard.

“*Fountain*” means a water fountain that is not established primarily for swimming or wading, but where swimming or wading is allowed, and that has a drain which is connected to a mechanical suction device for removing or recirculating the water.

“*Free chlorine*” means the concentration of hypochlorous acid and hypochlorite ion in the swimming pool water as measured with a DPD (diethyl-p-phenylene diamine) test kit or as measured by another method approved by the department.

“*Fully submerged outlet*” means an outlet that is completely under water when the water is at the normal operating level.

“*Gravity outlet*” means an outlet that directly connects to a tank or other structure that is at atmospheric pressure. Water flows through a gravity outlet by the natural head of water over the outlet.

“*Hose bib*” means a fresh-water outlet that is threaded to permit the attachment of a garden hose.

“*Hydrostatic relief valve*” means a relief valve installed in the bottom of the swimming pool and designed to operate automatically when the swimming pool is empty, relieving the groundwater pressure around the structure by allowing the groundwater into the swimming pool tank.

“*Inlet*” means a fitting or opening through which recirculation water enters the swimming pool.

“*Inspection agency*” means the department, or a city, county or district board of health that has executed with the department pursuant to the authority of Iowa Code chapters 28E and 135I an agreement to inspect swimming pool/spa facilities and enforce these rules. The authority of a city, county or district board of health is limited to the geographic area defined in the agreement executed with the department. Within the defined geographic area, the city, county or district board of health is the “local inspection agency.”

“Leisure river” means a closed-path channel of near constant depth with a river-like flow of water. A leisure river may include water features and play devices. Leisure rivers are also called “lazy rivers” or “slow rivers.”

“Lifeguard.”

1. “Certified lifeguard” means an individual who holds current certification in one of the following courses and, where applicable, current additional certification in American Red Cross first aid and American Red Cross or American Heart Association infant, child and adult CPR; two-person CPR, or equivalent first-aid and CPR certification approved by the department:

- American Red Cross Lifeguard Training
- YMCA Lifeguarding
- Boy Scouts of America Lifeguard

2. “Licensed lifeguard” means an individual who holds a current license from the National Pool and Waterpark Lifeguard Training Program in one of the following programs:

- National Pool and Waterpark Pool Lifeguard
- National Pool and Waterpark Lifeguard Training
- National Pool and Waterpark Deep Water Lifeguard

NOTE: Lifeguard, CPR and first-aid training programs will sometimes be renamed or restructured by the sponsoring organization. American Red Cross lifeguard training now includes first aid and CPR; the lifeguard receives the lifeguard certificate and a CPR certificate. Separate CPR and first-aid training is available from the American Red Cross, the American Heart Association, and other providers. If there is a question whether a specific training course will meet the requirements of these rules, information about the course should be submitted to the department for evaluation.

“Main drain” means the outlet(s) at the deepest part of a swimming pool or spa.

“Manufacturer’s specifications” means written guidelines established by a manufacturer for the installation and operation of the manufacturer’s equipment.

“Multisection water recreation pool” means a swimming pool with three or more distinct use areas such as, but not limited to, a zero-depth play area, a water slide landing area, a lap swim area, and a diving area.

“Outlet” means a fitting or opening, including the main drain, through which water leaves the swimming pool or spa.

“Outlet system” means an arrangement of components associated with one or more connected fully submerged outlets including the cover/grate(s), the sump(s), the piping, and the pump(s) if one or more pumps are directly connected to the outlet(s).

“Perimeter overflow gutter” means a weir and trough around the perimeter of a swimming pool that is used to skim the surface of the water and return the water to the treatment system.

“Plunge pool” means a pool designed to serve as a landing area for a water slide.

“Recirculation system” means the pump(s), piping, inlets, outlets, filtration system, chemical feed systems and accessories provided to convey and treat the swimming pool or spa water to meet the water quality standards in these rules.

“Reconstruction” means the replacement or modification of a swimming pool or spa shell or deck, a swimming pool or spa recirculation system, a perimeter overflow gutter or skimmer, or a bathhouse associated with a public swimming pool or spa. “Reconstruction” does not include the replacement of equipment or piping previously approved by the department, provided that the type and size of the equipment are not revised, nor does it include normal maintenance or repair.

“Residential swimming pool” means any swimming pool that is used, or intended to be used, in connection with a single-family residence and that is available only to the family of the householder and the householder’s private guests. A residential swimming pool used for any commercial purpose, including, but not limited to, swimming lessons or exercise classes, shall comply with the requirements of 15.4(6)“n.” A residential swimming pool used for commercial purposes for more than 60 hours in a calendar month shall be considered a public swimming pool.

“Shallow water” means those areas of a swimming pool where the water is 5 ft deep or less.

“Shallow water guard.”

1. “Certified shallow water guard” means a person who has current certification in American Red Cross basic water rescue, current certification in American Red Cross first aid, and current certification in American Red Cross or American Heart Association infant, child and adult CPR, or equivalent training approved by the department.

2. “Licensed shallow water guard” means a person who holds a current license from the National Pool and Waterpark Lifeguard Training Program as a National Pool and Waterpark Shallow Water Waterpark Lifeguard.

NOTE: Water safety, CPR and first-aid training programs will sometimes be renamed or restructured by the sponsoring organization. If there is a question whether a specific training course will meet the requirements of these rules, information about the course should be submitted to the department for evaluation.

“*Skimmer*” means a manufactured device designed to be directly connected to the recirculation pump suction and used to skim the swimming pool over a self-adjusting weir.

“*Spa*” means a structure, chamber, or tank, such as a hot tub or whirlpool, that is designed for recreational or therapeutic use and is designed not to be drained, cleaned, and refilled after each individual use. A spa is designed to provide a means of agitation. A swimming pool with a bench equipped with agitation is not considered a spa provided that the bench length is no more than 10 percent of the swimming pool perimeter and that the water temperature is maintained at 90°F or less. Rules 641—15.51(135I) and 641—15.52(135I) define minimum standards for the operation and design of spas.

“*Speed slide*” means a water slide which is designed to enter users into a plunge pool or other deceleration arrangement at a speed of 30 ft per second or more.

“*Spray pad*” means a constructed area equipped with water sprays or other water play features where the water is intended to contact the users. A spray pad includes no standing water. A spray pad uses water that is recirculated independently or from an associated swimming pool. Spray pads are also called “wet decks,” “splash pads,” “interactive play attractions,” “water recreation attractions,” and other names.

A play area with sprays or other features that includes no standing water and that uses only potable water that is not circulated (the water drains to waste) is not included in this definition.

“*Suction outlet*” means an outlet that is directly connected to the inlet side of a circulation pump.

“*Superchlorination*” means the addition of a chlorine disinfectant compound to a swimming pool or spa to a concentration at least ten times the combined chlorine concentration before the addition. Treatment of swimming pool or spa water with nonchlorine chemicals to eliminate or suppress combined chlorine is not superchlorination.

“*Swimming pool*” means a structure, chamber, tank, or area constructed of man-made material through which water is circulated and that is designed and operated for recreation, training, or competition that includes full body contact with the water. This definition includes, but may not be limited to, swimming pools, wading pools, spray pads, leisure rivers, water slides, and wave pools. The swimming pool may be either publicly or privately owned. This definition includes, but is not limited to, swimming pools operated by cities, counties, public and private schools, hotels, motels, camps, apartments, condominiums, and health clubs and country clubs.

1. “Class A swimming pool” means a swimming pool with a water surface area of 1500 ft² or more, except for wading pools.

2. “Class B swimming pool” means a swimming pool with a water surface area of less than 1500 ft².

“*Swimming pool slide*” means any device used to enter a swimming pool by sliding down an inclined plane or through a tube. “Swimming pool slide” as used in this chapter is equipment generally similar to a playground slide. A swimming pool slide shall have a slide path of 20 ft or less in length and a water flow down the slide of 20 gpm or less. A slide exceeding either of these criteria shall be a water slide.

“*Temporary spa*” means a spa which is installed or situated in one location for a period of less than 30 days.

“*Total bromine*” means the concentration of hypobromous acid, hypobromite ion and nitrogen-bromine compounds in the swimming pool water as measured with a DPD (diethyl-p-phenylene diamine) test kit or as measured by another method approved by the department.

“*Tri-chlor*” means trichloro-s-triazinetriene. Tri-chlor is a form of chlorine that includes cyanuric acid in its formulation.

“*Unblockable*,” when applied to a cover/grate for a fully submerged outlet, means a size and shape that cannot be fully covered by an 18-inch by 23-inch mat with 4-inch-diameter rounded corners and the differential pressure generated by the flow through the uncovered open area is not enough to cause body entrapment. “Unblockable” is evaluated by the methods specified in the ASME standard.

“*Wading pool*” means a swimming pool that is no more than 24 inches deep at any point and that is primarily intended for use by young children for general recreation or training.

“*Water slide*” means a recreational ride which is a sloped trough-like or tubular structure using water as a lubricant and as a method of regulating rider velocity and which terminates in a plunge pool, swimming pool, or in a specially designed deceleration structure. “Water slide” includes appurtenant structures and devices, such as a plunge pool, pump reservoir, recirculation equipment, flume pumps, and access structures, when they are provided.

“*Wave pool*” means a swimming pool of special shape and design which is provided with wave-generating equipment.

“*Zero-depth pool*” means a swimming pool in which the pool floor intersects the water surface along at least one side of the pool. This definition does not include wading pools.

15.3(2) Abbreviations.

“*AFO*” means aquatic facility operator.

“*AGA*” means American Gas Association, 400 N. Capitol Street, NW, Washington, DC 20001.

“*ANSI*” means American National Standards Institute, 25 West 43rd Street, New York, NY 10036.

“*APSP*” means the Association of Pool & Spa Professionals (formerly National Spa and Pool Institute (NSPI)), 2111 Eisenhower Avenue, Alexandria, Virginia 22314.

“*ASME*” means American Society of Mechanical Engineers, Three Park Avenue, New York, NY 10016-5990.

“*ASME standard*” means ASME/ANSI A112.19.8a-2008, “Suction Fittings for Use in Swimming Pools, Wading Pools, Spas, and Hot Tubs.” The standard sets performance requirements and test methods for pool and spa fittings, covers and grates for physical strength, ultraviolet light resistance, and hair and body entrapment prevention. The standard can be purchased from ANSI by calling (212)642-4980 or at <http://webstore.ansi.org/>.

“*AWWA*” means American Water Works Association, 6666 West Quincy Avenue, Denver, CO 80235.

“*BTU*” means British thermal unit.

“*CPO*®” means certified swimming pool/spa operator.

“*CPR*” means cardiopulmonary resuscitation.

“*feet*” means feet of water ($\text{feet} \times 0.43 = \text{psi}$) when used in discussing pump requirements.

“*ft*” means foot or feet (distance).

“*ft²*” means square foot or square feet.

“*gal*” means gallon(s).

“*gpm*” means gal per minute.

“*in Hg*” means inches of mercury ($\text{in Hg} \times 0.49 = \text{psi}$).

“*in²*” means square inch(es).

“*LAF*” means licensed aquatic facility technician.

“*mg/L*” means milligram(s) per liter.

“*mV*” means millivolts.

“*NRPA*” means National Recreation and Park Association, 22377 Belmont Ridge Road, Ashburn, VA 20148.

“*NSF*” means NSF International (formerly National Sanitation Foundation), 789 N. Dixboro Road, P.O. Box 130140, Ann Arbor, MI 48113-0140.

“*NSPF*®” means National Swimming Pool Foundation, 4775 Granby Circle, Colorado Springs, CO 80919.

“*ORP*” means oxidation-reduction potential.

“*ppm*” means parts per million; mg/L and ppm are equivalent terms.

“*PPSO*” means professional pool and spa operator.

“*psi*” means pounds per square inch.

“*sec*” means second (time).

“*Standard 50*” means NSF/ANSI Standard 50, “Circulation System Components for Swimming Pools, Spas, or Hot Tubs.”

“*TDH*” means total dynamic head.

“*UL*” means Underwriters Laboratories, 333 Pfingsten Road, Northbrook, IL 60062-2096.

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SWIMMING POOLS

641—15.4(135I) Swimming pool operations. Swimming pools shall be operated in a safe, sanitary manner and shall meet the following operational standards.

15.4(1) Filtration and recirculation.

a. Filtration. A swimming pool, except a fill and drain wading pool, shall have a filtration system in good working condition which provides water clarity in compliance with the water quality standards of 15.4(2).

b. Recirculation. The recirculation system of a swimming pool shall meet the following requirements:

(1) During the operating season, pumps, filters, disinfectant feeders, flow indicators, gauges, and all related components of the swimming pool water recirculation system shall be operated continuously except for backwashing or servicing.

(2) The recirculation system shall have an operating pressure gauge located in front of the filter if it is a pressure filter system. A vacuum filter system shall have a vacuum gauge located between the filter and the pump.

(3) The recirculation system shall have inlets adequate in design, number, location, and spacing to ensure effective distribution of treated water and maintenance of uniform disinfectant residual throughout the swimming pool.

(4) Swimming pools shall have a means for skimming the pool water surface.

1. Each skimmer shall have an easily removable basket or screen upstream from any valve. Self-adjusting weirs shall be in place to provide skimming action.

2. Gutter or skimmer drainage shall be sufficient to minimize flooding and prevent backflow of skimmed water into the swimming pool.

c. Wastewater. Backwash water from a swimming pool shall be discharged through an air break or an air gap.

d. Water supply. The water supplied to a swimming pool shall be from a water supply meeting the requirements of the department of natural resources for potable water.

(1) Water supplied to a swimming pool shall be discharged to the pool system through an air gap or a reduced-pressure principle backflow device meeting AWWA C-511-97, “Reduced-Pressure Principle Backflow-Prevention Assembly.”

(2) Each hose bib at a facility shall be equipped with an atmospheric vacuum breaker or a hose connection backflow preventer.

e. Swimming pool water heaters.

(1) Electric water heaters shall bear the seal of UL.

(2) Gas-fired water heaters shall bear the seal of the AGA and shall be equipped with a pressure relief valve.

(3) Fuel-burning water heaters shall be vented to the outside in accordance with the Iowa state plumbing code.

(4) Each indoor swimming pool equipment room with fuel-burning water heating equipment shall have one or more openings to the outside of the room for the provision of combustion air.

f. Fill and drain wading pools. Each fill and drain wading pool shall be drained at least once every 12 hours and left empty when the pool is not open for use.

15.4(2) Water quality and testing.

a. Disinfection.

(1) Swimming pool water shall have a free chlorine residual of at least 1.0 ppm and no greater than 8.0 ppm, or a total bromine residual of at least 2.0 ppm and no greater than 18 ppm when the swimming pool is open for use, except as given in Table 1.

(2) The swimming pool shall be closed if the free chlorine is measured to be less than 0.6 ppm or the total bromine is measured to be less than 1.0 ppm.

(3) The swimming pool shall be closed if a free chlorine measurement exceeds 8.0 ppm or if the total bromine measurement exceeds 18 ppm, except as given in Table 1.

(4) If an ORP controller with a readout meeting the requirements of 15.4(2) "f"(4) is installed on the swimming pool system, the swimming pool water shall have an ORP of at least 700 mV, but no greater than 880 mV, except as given in Table 1. The swimming pool shall be closed if the ORP is less than 650 mV or greater than 880 mV.

(5) The swimming pool shall be closed if the cyanuric acid concentration in the swimming pool water exceeds 80 ppm. The swimming pool may be reopened when the cyanuric acid concentration is 40 ppm or less.

(6) No cyanuric acid shall be added to an indoor swimming pool after May 4, 2005, except through an existing chemical feed system designed to deliver di-chlor or tri-chlor. No cyanuric acid in any form shall be added to an indoor swimming pool after May 31, 2008.

Table 1

Preferred Operating Range			Acceptable Operating Range		
ORP (mV)	Free Cl (ppm)	Total Br (ppm)	ORP (mV)	Free Cl (ppm)	Total Br (ppm)
700-880	1.0-8.0	2.0-18.0	700-880	0.50-0.90	1.0-2.0
			650-700 [#]	1.0-8.0	2.0-18.0
			650-700 [†]	8.2-10.0	18.5-22.0

[#] If these conditions occur on any 5 consecutive days or on any 10 days within a 14-day period, the facility management shall evaluate water parameters including, but not limited to, cyanuric acid, pH, combined chlorine, and phosphates (ortho- and total); and other conditions at the swimming pool. The facility management shall modify parameters and conditions as practical to bring the ORP to a minimum of 700 mV. The evaluation shall be completed within 30 days after the low ORP condition is known to the facility management. A written report of the evaluation shall be kept with the pool records.

[†] If these conditions occur on any 3 consecutive days or on any 7 days within a 14-day period, the facility management shall notify the local inspection agency and shall cause the conditions at the swimming pool specified in the previous footnote and the function of the ORP equipment to be investigated by a professional pool service company. A written report detailing source water parameters, pool water parameters, pool design (including information about the installed mechanical and chemical equipment), other conditions affecting the disinfectant concentration and the ORP, and the actions taken to increase ORP relative to the disinfectant residual shall be submitted to the local inspection agency within 30 days after the low ORP condition is known to the facility management.

b. pH level. The pH of swimming pool water shall be 7.2 to 7.8. An inspection agency may require that a swimming pool be closed if the pH is less than 6.8 or greater than 8.2.

c. Water clarity. A swimming pool that is less than 8 ft deep shall be closed if the grate openings on the main drain are not clearly visible from the deck. A swimming pool that is 8 ft deep or deeper shall be closed if the main drain is not clearly visible from the deck.

d. Bacteria detection.

(1) If coliform bacteria are detected in a sample taken in accordance with 15.4(2) "e"(6), the swimming pool shall be superchlorinated and a check sample shall be taken when the disinfectant residual is within the requirements of paragraph "a" above. If coliform bacteria are detected in the check sample, the swimming pool shall be closed. The swimming pool may reopen when no

coliform bacteria are detected in a swimming pool water sample taken when the pool water meets the requirements of paragraphs "a," "b" and "c" above.

(2) The facility management shall notify the local inspection agency of the positive bacteriological result within one business day after the facility management has become aware of the result.

e. Test frequency. The results of the tests required below shall be recorded in the swimming pool records.

(1) The disinfectant residual in the swimming pool water shall be tested or the ORP of the swimming pool water shall be checked each day within one-half hour of the swimming pool opening time and at intervals not to exceed four hours thereafter until the swimming pool closing time. For swimming pools at condominiums, apartments or homeowners associations with 25 or fewer living units, testing must be performed at least once each day that the swimming pool is available for use.

If the swimming pool is equipped with an automatic controller with a readout or local printout of ORP meeting the requirements of 15.4(2) "f"(4), the operator may make visual readings of ORP in lieu of manual testing, but the swimming pool water shall be tested manually for disinfectant residual at least twice per day. Both ORP and disinfectant residual shall be recorded when manual testing is done. The operator shall specify in the swimming pool records which results are from the manual tests.

(2) The pH of the swimming pool water shall be tested each day within one-half hour of the swimming pool opening time and at intervals not to exceed four hours thereafter until the swimming pool closing time. For swimming pools at condominiums, apartments or homeowners associations with 25 or fewer living units, testing for pH must be performed at least once each day that the swimming pool is available for use.

If the swimming pool is equipped with an automatic controller with a readout or local printout of pH meeting the requirements of 15.4(2) "f"(5), the operator may make visual readings of pH in lieu of manual testing, but the swimming pool water shall be tested manually for pH at least twice per day. The operator shall specify in the swimming pool records which results are from the manual tests.

(3) The swimming pool water shall be tested for total alkalinity at least once in each week that the swimming pool is open for use. The swimming pool shall be tested for calcium hardness at least once in each month that the swimming pool is open for use.

(4) If a chlorine chemical is used for disinfection, the swimming pool water shall be tested for combined chlorine at least once in each week that the swimming pool is open for use.

(5) If cyanuric acid or a stabilized chlorine is used at a swimming pool, the swimming pool water shall be tested for cyanuric acid at least once in each week that the swimming pool is open for use.

(6) At least once in each month that a swimming pool is open for use, the facility management shall submit a sample of the swimming pool water to a laboratory certified by the department of natural resources for the determination of coliform bacteria in drinking water. The sample shall be analyzed for total coliform.

f. Test equipment.

(1) Each facility shall have functional water testing equipment for free chlorine and combined chlorine, or total bromine; pH; total alkalinity; calcium hardness; and cyanuric acid (if cyanuric acid or a stabilized chlorine is used at the facility).

(2) The test equipment shall provide for the direct measurement of free chlorine and combined chlorine from 0 to 10 ppm in increments of 0.2 ppm or less over the full range, or total bromine from 0 to 20 ppm in increments of 0.5 ppm or less over the full range.

(3) The test equipment shall provide for the measurement of swimming pool water pH from 7.0 to 8.0 with at least five increments in that range.

(4) A controller readout used in lieu of manual disinfectant residual testing shall be a numerical analog or digital display (indicator lights are not acceptable) with an ORP scale with a range of at least 600 to 900 mV with increments of 20 mV or less.

(5) A controller readout used in lieu of manual pH testing shall be a numerical analog or digital display (indicator lights are not acceptable) with a pH range at least equal to the range required in 15.4(2) "f"(3) with increments of 0.2 or less over the full range.

g. Operator availability. A person knowledgeable in testing water and in operating the water treatment equipment shall be available whenever a swimming pool is open for use.

15.4(3) Chemical feed equipment and cleaning.

a. Chemical feed equipment.

(1) Equipment for continuous feed of chlorine, a chlorine compound or a bromine compound to the swimming pool water shall be provided and shall be operational. The equipment shall be adjustable in at least five increments over its feed capacity. Where applicable, the chemical feeder shall be listed by NSF or another listing agency approved by the department for compliance with Standard 50.

(2) Equipment for the continuous feed of a chemical for pH adjustment of the swimming pool water shall be provided and shall be operational for each Class A swimming pool and for each swimming pool constructed after July 1, 1998. Where applicable, the chemical feeder shall be listed by NSF or another listing agency approved by the department for compliance with Standard 50.

b. Cleaning.

(1) The inspection agency may require that a swimming pool be drained and scrubbed with a disinfecting agent prior to further usage.

(2) A vacuum system shall be provided to remove dirt from the bottom of the swimming pool.

15.4(4) Safety.

a. Chemical safety.

(1) No disinfectant chemical, pH control chemical, algaecide, shock treatment chemical, or any other chemical that is toxic or irritating to humans may be added to the swimming pool water from the deck of the swimming pool while the swimming pool is in use. When chemical additions are made from the deck, the swimming pool shall be closed from use for at least one-half hour. The operator shall test the swimming pool water as appropriate before allowing use of the swimming pool. The chemical addition and the test results shall be recorded in the swimming pool records.

(2) Swimming pool treatment chemicals shall be stored and handled in accordance with the manufacturer's recommendations.

(3) Material safety data sheets (MSDS) for the chemicals used at the pool shall be at the facility in a location known and readily accessible to the facility staff.

(4) Chemical storage containers shall be clearly labeled.

(5) A chemical hazard warning sign shall be placed at the entrance of a room where chemicals are used or stored or where bulk containers are located.

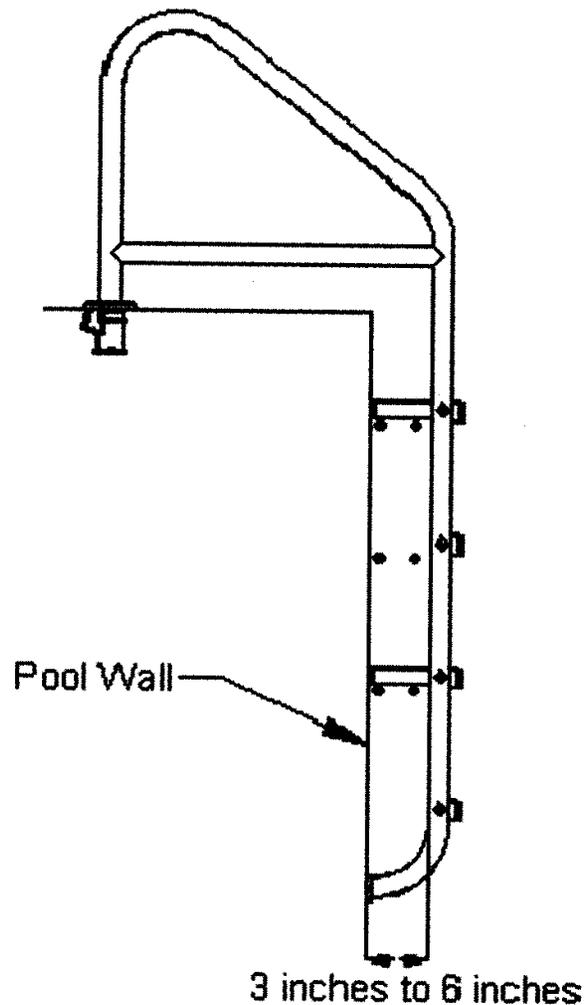
b. Stairs, ladders, recessed steps, and ramps.

(1) Ladders or recessed steps shall be provided in the deep portion of a swimming pool. Stairs, ladders, recessed steps, or ramps shall be provided in the shallow portion if the vertical distance from the bottom of the swimming pool to the deck is more than 2 ft.

(2) Ladders, ladder rungs and ramps shall be securely anchored.

(3) The distance between the swimming pool wall to the vertical rail of a ladder shall be no greater than 6 inches and no less than 3 inches. The lower end of each ladder rail shall be securely covered with a smooth nonmetallic cap. The lower end of each ladder rail shall be within 1 inch of the swimming pool wall.

Figure 1



- (4) Stairs, ladder rungs, ramps and recessed steps shall be slip-resistant.
 - (5) If a swimming pool is over 30 ft wide, recessed steps, ladders, ramps, or stairs shall be installed on each side. If a stairway centered on the shallow end wall of the swimming pool is within 30 ft of each side of the swimming pool, that end of the swimming pool shall be considered in compliance with this subparagraph.
 - (6) Each set of recessed steps shall be equipped with a securely anchored grab rail on each side of the recessed steps.
 - (7) Each set of stairs and each ramp shall be equipped with a securely anchored handrail(s).
 - (8) When stairs are provided for entry into a swimming pool, a stripe at least 1 inch wide of a color contrasting with the step surface and with the swimming pool floor shall be marked at the top front edge of each tread. The stripe shall be slip-resistant.
- c. Diving areas.*
- (1) No diving shall be permitted in areas where the water is 5 ft deep or less except for purposes of competition or training. The diving shall be supervised by a lifeguard, swim instructor or swim coach.
 - (2) Starting blocks shall only be used for competition or training purposes under the supervision of a lifeguard, swim instructor, or swim coach. Starting blocks and starting block installation shall meet the requirements of the competition governing body (National Collegiate Athletic Association, USA Swimming, or National Federation of State High School Associations). When the swimming pool is

open for general use, the starting blocks shall be secured from use by removal, covering, or signage and active supervision.

(3) Diving boards shall be permitted only if the diving area dimensions conform to the minimum requirements indicated in Figure 2, Table 2 and Table 3. Alternative diving well configurations may be used, subject to the approval of the department.

(4) There shall be a completely unobstructed clear distance of 13 ft above the diving board, measured from the center of the front end of the board. This area shall extend at least 8 ft behind, 8 ft to each side, and 16 ft ahead of the measuring point.

(5) Diving boards and platforms over 3 meters in height are prohibited except where approved by the department.

(6) Diving boards and platforms shall have a slip-resistant surface.

(7) Where the top of a diving board or platform is more than 18 inches above the deck, stairs or a ladder shall be provided for access to the diving board or platform.

(8) Handrails shall be provided at all steps and ladders leading to diving boards which are more than 32 inches above the deck.

(9) A platform or diving board that is 32 inches or more above the swimming pool deck shall have a guardrail on both sides. The guardrails shall be at least 36 inches high and shall extend to the edge of the deck. The guardrails shall have at least one horizontal mid-bar.

(10) Supports, platforms, and steps for diving boards shall be of substantial construction and of sufficient structural strength to safely carry the maximum anticipated load.

NOTE: The information contained in Figure 2 and Tables 2 and 3 is for swimming pools constructed prior to March 14, 1990. Swimming pools constructed after March 14, 1990, shall meet the requirements contained in 15.5(13) "a."

When determining distances set out in Tables 2 and 3, measurements shall be taken from the top center of the front edge of the diving board. The reference water level shall be the midpoint of the skimmer opening for a skimmer pool or a stainless steel gutter system with surge weirs. The reference water level for a gutter pool shall be the top of the gutter weir.

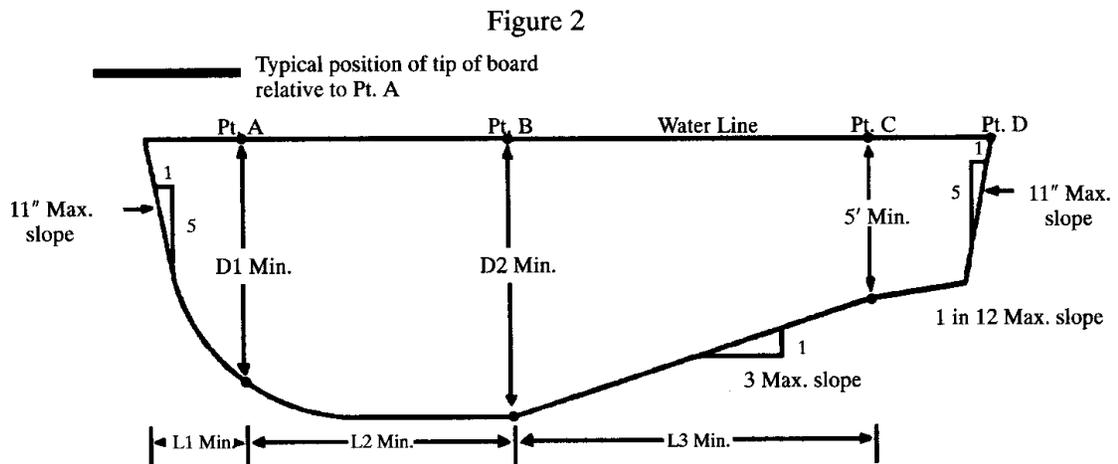


Table 2

Diving Board Height Above Water	Maximum Diving Board Length	Minimum Dimensions				
		D1	D2	L1	L2	L3
Deck level to 2/3 meter	10 ft	7 ft	8.5 ft	2.5 ft	8 ft	10.5 ft
Greater than 2/3 meter to 3/4 meter	12 ft	7.5 ft	9 ft	3 ft	9 ft	12 ft
Greater than 3/4 meter to 1 meter	16 ft	8.5 ft	10 ft	4 ft	10 ft	15 ft
Greater than 1 meter to 3 meters	16 ft	11 ft	12 ft	6 ft	10.5 ft	21 ft

Table 3

Diving Board Height Above Water	Minimum Distance		
	To Pool Side	To 1-Meter Diving Board	To 3-Meter Diving Board
Deck level to 1 meter	9 ft	8 ft	10 ft
Greater than 1 meter	11 ft	10 ft	10 ft

d. Lifeguards and shallow water guards.

(1) Except for wading pools and spray pads, lifeguards are required at municipal and school swimming pools of any size and other swimming pools having a water surface area of 1500 ft² or larger. Swimming pools operated by apartments, condominiums, country clubs, neighborhoods, manufactured home communities, or mobile home parks are exempt from lifeguard requirements.

(2) Shallow water guards may be used at plunge pools which are 5 ft deep or less and at wading pools.

(3) For open recreation swimming, there shall be at least one lifeguard guarding the pool at all times for up to 30 swimmers in the water; for over 30 swimmers in the water, there shall be at least two lifeguards on duty, one of whom shall be guarding the pool at all times for up to 125 swimmers in the water. An additional lifeguard shall be provided for each additional 125 swimmers in the water or fraction thereof.

NOTE: This is the minimum lifeguard coverage acceptable under these rules. It is the responsibility of the management of each facility to evaluate the facility configuration, the features of the facility, including water slides, spray pads, play features, etc., the patrons, and the type of use, and to determine the facility-specific requirements for supervision by lifeguards.

(4) For a structured swimming program, such as lap swim, competitive swimming, water exercise classes, swim lessons and physical education classes, a lifeguard is not required provided the program is supervised by an instructor, teacher, or coach who is a lifeguard or who has current certification from the American Red Cross in basic water rescue, first aid, and infant, child and adult CPR, or equivalent training approved by the department. An instructor, teacher or coach may be responsible for a maximum of 30 persons within a structured activity. If more than 30 persons are involved in a structured activity, a second qualified supervisor must be present.

(5) Water slide attendants. Each water slide shall have a minimum of two attendants, one stationed at the top of the slide and one at the bottom of the slide. If the plunge pool is shallow, the water slide attendants shall be either lifeguards or shallow water guards. If the plunge pool includes deep water, the water slide attendants shall be lifeguards. Where the water slide attendant stationed at the bottom of a slide which empties into a swimming pool is a shallow water guard, the attendant shall only be responsible for guarding the water slide landing area.

The department may approve alternate water slide management based on a review of the slide and swimming pool configuration. Alternate water slide management plans shall be in writing and shall be at the facility during the operating season.

If two or three water slides start at the same platform and the distance between the centerlines of any two start structures is 10 ft or less, one attendant may supervise the slides. If two or three water slides terminate within the same landing area, one attendant may supervise the landing area.

e. Lifeguard chairs. For outdoor swimming pools where lifeguards are required by rule, at least one elevated lifeguard chair or station shall be provided for a swimming pool with a water surface area of 2000 to 4000 ft² inclusive; at least two chairs shall be provided if the area is 4001 to 6000 ft²; and at least three chairs shall be provided if the area is 6001 ft² or more. Swimming pools are not required to have more than three lifeguard chairs or stations. This requirement does not apply to wave pools, leisure rivers, spray pads, or wading pools.

f. Emergency equipment and facilities.

(1) Except for wading pools, a minimum of one unit of lifesaving equipment shall be provided for each 1500 ft² of water surface area or fraction thereof. The area of a swimming pool where the water is 2 ft deep or less may be subtracted from the total area for this requirement. A swimming pool is not required to have more than ten units of lifesaving equipment.

(2) A unit of lifesaving equipment consists of one of the following:

1. A U.S. Coast Guard-recognized ring buoy fitted with a ¼-inch diameter line with a length of at least one-half the width of the pool, but no more than 60 ft; or
2. A life pole, or a “shepherd’s crook” of at least 8 ft in length, and having blunted ends; or
3. A rescue buoy made of lightweight, hard, buoyant plastic with molded handgrips along each side and provided with a 4- to 6-ft tow rope and shoulder strap; or
4. A rescue tube made of a soft, strong foam material 3 inches by 6 inches by 40 inches with a molded strap providing a ring at one end and a hook at the other. Attached to the end with the ring shall be a 6-ft-long towline with a shoulder strap; or
5. Any other piece of rescue equipment approved by the department.

NOTE: Rescue equipment identified in 15.4(4) “f”(2)“3” and 15.4(4) “f”(2)“4” above shall be used only at swimming pools where lifeguards are employed. If a facility employs lifeguards (whether required by rule or not), the lifeguards shall be provided with the minimum equipment required by their training including, but not necessarily limited to, rescue tubes and personal CPR masks.

(3) Lifesaving equipment shall be mounted in conspicuous places around the swimming pool deck during normal operations.

(4) A swimming pool facility shall have a first-aid kit which contains, at a minimum, the following:

1. Band-Aids.
2. Sterile 4" × 4" bandage compress.
3. Self-adhering gauze bandage.
4. Disposable gloves.
5. Chemical cold compress.

Where lifeguards are not provided, the first-aid kit shall be prominently mounted in the swimming pool enclosure, or a sign stating its location shall be posted near the swimming pool. The first-aid kit shall be accessible when the swimming pool is open.

(5) A standard spine board with straps and a head immobilizer shall be provided at each swimming pool where lifeguards are required by rule.

(6) Except for wading pools and spray pads, each swimming pool where lifeguards are not provided shall have a designated emergency telephone or equivalent emergency communication system that can be operated without coins. The communication system shall be available to users of swimming pools when the swimming pool is open. When the telephone is not within the confines of the swimming pool enclosure, the location of the emergency telephone shall be posted in at least one conspicuous place within the swimming pool enclosure. Instructions for emergency use of the telephone shall be posted near the telephone.

At each swimming pool where lifeguards are employed, a telephone shall be available to the swimming pool staff for emergency purposes.

g. Water level. Water level in swimming pools shall be maintained at the skimming level.

h. Fully submerged outlets. Each outlet, including the main drain(s), shall be designed to prevent user entrapment. A swimming pool shall be closed if the cover/grate of a fully submerged outlet is missing or broken.

(1) Each fully submerged outlet shall have a cover/grate that has been tested for compliance with the requirements of the ASME standard by a testing agency approved by the department or that is certified for compliance by an engineer licensed in Iowa.

1. The cover/grate for an outlet system with a single fully submerged outlet shall have a flow rating of at least 100 percent of the maximum system flow rate. The combined flow rating for the cover/grates for an outlet system with more than one fully submerged outlet shall be at least 200 percent of the maximum system flow rate.

The maximum system flow rate for a main drain system is at least the design filter flow rate, but may include play feature and water slide flow. The maximum system flow rate for other fully submerged outlets is the design flow rate of the pump(s) directly connected to the outlet system.

2. Fully submerged outlet cover/grates shall not be removable without the use of tools.

3. Purchase records and product information that demonstrate compliance shall be maintained by the facility for at least five years from the time the cover/grate is purchased. If a field fabricated cover/grate is certified for compliance to the ASME standard by an engineer licensed in Iowa, a copy of the certification letter shall be kept at the facility for at least five years from the certification date.

(2) A swimming pool with a single fully submerged outlet that is not unblockable and that is directly connected to a pump shall be closed if the outlet does not have a cover/grate that complies with the ASME standard.

If a swimming pool has two or more fully submerged outlets on a single surface that are all less than 3 ft apart on center, are not unblockable, and are directly connected to a pump, the swimming pool is considered to have a single fully submerged outlet.

(3) A swimming pool with a single fully submerged outlet that is not unblockable and that is directly connected to a pump shall be closed if the outlet system is not equipped with a safety vacuum release system that is listed for compliance with ASME/ANSI A112.19.17-2002, "Manufactured Safety Vacuum Release Systems (SVRS) for Residential and Commercial Swimming Pool, Spa, Hot Tub, and Wading Pool Suction Systems," by a listing agency approved by the department; or another vacuum release system approved by the department.

1. Purchase records and product information that demonstrate compliance shall be maintained by the facility for at least five years from the time the SVRS is purchased or another approved system is installed.

2. An SVRS shall be installed in accordance with the manufacturer's instructions.

3. An SVRS shall be tested for proper function at the frequency recommended by the manufacturer, but at least once in each month the swimming pool is operated. The date and result of each test shall be recorded.

(4) In lieu of compliance with subparagraphs (1), (2) and (3) above, a fully submerged outlet in a swimming pool may be disabled with the approval of the department, except that an equalizer in a skimmer may be plugged without department approval. The management of the swimming pool shall submit to the department information including, but not necessarily limited to:

1. The area and volume of the pool;

2. The functional areas of the pool and the depths in those areas;

3. Detailed information about the inlet system, including the location of the inlets, the depth of the inlets, and the type of inlet fitting;

4. Detailed information about the overflow system, gutter or skimmer, number of skimmers, and pipe sizes;

5. Pump information and flow rates for the outlet system;

6. Filter type, number of filters, the size of the filter(s), and whether multiple filters are backwashed together or separately.

If the department approves the application to disable the outlet, the outlet valve shall be closed and the valve secured by removing the handle, by locking the handle closed, or by another method approved

by the department. The outlet may be physically disconnected from the pump system at the option of the facility management.

i. Surface finish and float lines.

(1) The bottom and sides of a swimming pool shall be white or a light color. This does not prohibit painting or marking racing lines, stairs or turn targets with contrasting colors.

(2) The swimming pool walls and floor shall have a smooth surface to facilitate cleaning.

(3) The boundary between shallow and deep water (5 ft) shall be marked by a float line with floats spaced no more than 5 ft apart. The float line shall be installed on the shallow side of the boundary within 12 inches of the boundary. When the slope of the floor of a swimming pool exceeds 1 ft vertical to 12 ft horizontal at a depth of less than 5 ft, the float line shall be placed on the shallow side of the slope change within 12 inches of the slope change in lieu of a float line at the 5 ft depth.

(4) A wave pool shall be equipped with a float line with floats spaced no more than 5 ft apart. The float line shall be located at least 6 ft from the deep-end wall. Users shall not be permitted between the float line and the deep-end wall.

(5) The landing area for a swimming pool slide or a water slide that terminates in a swimming pool shall be delineated by a float line or as approved by the department.

A float line is not required when the landing area is in deep water provided the distance between the slide and any diving board(s) meets the requirements for diving board spacing. The distance between the side of the slide at the slide's terminus and the swimming pool wall shall be in accordance with the manufacturer's recommendations, but shall be at least 8 ft.

A float line is not required for a slide that is designed for toddlers and young children and that terminates in water that is 2 ft deep or less. The landing area shall be designated by a brightly colored pad securely fastened to the floor of the swimming pool or by painting the floor at the end of the slide.

j. Depth marking.

(1) Depth markers shall be painted or otherwise marked on the deck within 3 ft of the edge of the swimming pool. The depth of a wave pool shall also be marked on the side walls of the wave pool, above the maximum static water level, where the depth is 3 ft or more, and on the deep-end wall of the wave pool. Depth markers are not required at the zero-depth end of a wading pool, wave pool, or a zero-depth swimming pool. Depth markers are not required at a plunge pool on the flume discharge end or on the exit end if stairs are used for exit.

(2) Depth markers shall be located at 1-ft depth intervals, but not more than 25 ft apart measured between the centers of the depth markers around the area of a swimming pool which has a water depth of 5 ft or less.

(3) Depth markers shall be located not more than 25 ft apart measured between the centers of the depth markers around the deep end of the swimming pool. The words "Deep Water" may be used in place of numerals.

(4) In lieu of subparagraph (2) above, the maximum depth of a wading pool may be posted at each entrance to a wading pool enclosure and at one conspicuous location inside the wading pool enclosure in letters or numbers at least 3 inches high.

(5) The depth of a leisure river shall be posted at the entrance(s) to the leisure river in characters at least 3 inches high. The depth of the leisure river shall be marked on the side wall of the leisure river above the static water level at intervals not to exceed 50 ft on center. The depth of the leisure river shall be marked on the deck in the areas where users are permitted. The depth markers shall be within 3 ft of the edge of the leisure river at intervals not to exceed 25 ft on center. The depth markers at a leisure river constructed before May 4, 2005, are not required to be changed until the deck or channel structure is replaced or repaired.

(6) "No Diving" or equivalent wording or graphics shall be marked on the swimming pool deck within 3 ft of the edge of the swimming pool where the water is shallow and at other pool areas determined by management. The markers shall be 25 ft apart or less, center to center, around the perimeter of the area. This marking is not required for wading pools or at the zero-depth end of a wave pool or of a zero-depth swimming pool. "No Diving" or equivalent wording or graphics shall be marked on the deck of a leisure river in areas where users are permitted. The "No Diving" markers shall be within 3 ft of the

edge of the leisure river at intervals not to exceed 25 ft on center. The “No Diving” markers at a leisure river constructed before May 4, 2005, are not required to be changed until the deck or channel structure is replaced or repaired.

(7) Letters, numbers, and graphics marked on the deck shall be slip-resistant, of a color contrasting with the deck and at least 4 inches in height.

k. Deck safety.

(1) Decks shall be maintained slip-resistant, and free of litter, obstructions and tripping hazards.

(2) Glass objects, other than eyeglasses and safety glass doors and partitions, shall not be permitted on the deck.

(3) There shall be no underwater or overhead projections or obstructions which would endanger swimmer safety or interfere with proper swimming pool operation.

l. Fencing.

(1) Except for a fill and drain wading pool, a circulated wading pool that is drained when not in use, or a spray pad, a swimming pool shall be enclosed by a fence, wall, building, or combination thereof not less than 4 ft high. The enclosure shall be constructed of durable materials.

(2) A fence, wall, or other means of enclosure shall have no openings that would allow the passage of a 4-inch sphere, and shall not be easily climbable by toddlers. The distance between the ground and the top of the lowest horizontal support accessible from outside the facility, or between the two lowest horizontal supports accessible from outside the facility, shall be at least 45 inches. A horizontal support is considered accessible if it is on the exterior of the fence relative to the swimming pool, or if the gap between the vertical members of the fence is greater than 1¼ inches.

(3) At least one gate or door with an opening of at least 36 inches in width shall be provided for emergency purposes. When closed, gates and doors shall comply with the requirements of (2) above. Except where lifeguard or structured program supervision is provided whenever the swimming pool is open, gates and doors shall be self-closing and self-latching.

(4) If a wading pool is within 50 ft of a swimming pool, the wading pool shall have a barrier at least 36 inches high separating it from the swimming pool. A barrier installed after May 4, 2005, shall have no openings that would allow the passage of a 4-inch sphere and shall not be easily climbable by toddlers. The barrier shall have at least one 36-inch-wide gate or door. Gates and doors shall be lockable. Except where lifeguard supervision is provided, gates and doors shall be self-closing and self-latching.

The department may approve alternate management of the area between the wading pool and swimming pool at a facility where lifeguards are provided whenever the pools are open. The alternate management plan shall be in writing and shall be at the facility when the pools are open.

(5) An indoor swimming pool shall be enclosed by a barrier at least 3 ft high if there are sleeping rooms, hallways, apartments, condominiums, or permanent recreation areas which are used by children and which open directly into the swimming pool area. No opening in the barrier shall permit the passage of a 4-inch sphere. The barrier shall not be easily climbable by toddlers. There shall be at least one 36-inch-wide gate or door through the barrier. Gates and doors shall be lockable. Except where lifeguard supervision is provided whenever the pool is open, gates and doors shall be self-closing and self-latching.

(6) A wave pool shall have a continuous barrier along the full length of each side of the wave pool. The barrier shall be at least 42 inches high and be installed no more than 3 ft from the side of the wave pool. Wave pool users shall not be permitted in this area.

m. Electrical.

(1) Electrical outlets. Each electrical outlet in the deck, shower room, and pool water treatment equipment areas shall be equipped with a properly installed ground fault circuit interrupter (GFCI) at the outlet or at the breaker serving the outlet. Electrical outlets energized through an ORP/pH controller are not required to have a separate GFCI if the controller is equipped with a GFCI or is energized through a GFCI breaker. GFCI receptacles and breakers shall be tested at least once in each month that the swimming pool is in operation. Testing dates and results shall be recorded in the pool records.

(2) Lighting.

1. Artificial lighting shall be provided at a swimming pool which is to be used at night or which does not have adequate natural lighting so that all portions of the swimming pool, including the bottom and main drain, may be clearly seen.

2. Underwater lights and fixtures shall be designed for their intended use. When the underwater lights operate at more than 15 volts, the underwater light circuit shall be equipped with a GFCI. When an underwater light needs to be repaired, the electricity shall be shut off until repairs are completed.

3. For outdoor swimming pools, no electrical wiring, except for overhead illumination, shall extend over a swimming pool.

n. Chlorine gas and carbon dioxide.

(1) Chlorine gas feed equipment and full and empty chlorine cylinders shall be housed in a room or building used exclusively for that purpose during the pool operation season. Chlorine gas installations constructed prior to March 14, 1990, that are housed within chain-link fence or similar enclosure may be used provided that the chlorine cylinders are protected from direct sunlight and the applicable requirements below are met.

1. A chlorine gas room or building shall have an airtight exhaust system which takes its suction near the floor and discharges out of doors in a direction to minimize the exposure to swimming pool patrons. The system shall provide one air change every four minutes.

2. An air intake shall be provided near the ceiling.

3. The exhaust fan shall be operated from a switch in a nearby location outside the chlorine room or building. The switch shall be clearly labeled "Chlorine Exhaust Fan."

4. The discharge from the exhaust system shall be outside the pool enclosure.

5. Artificial lighting shall be provided in the chlorine room or building.

6. The door of a chlorine room or building shall be secured in an open position whenever the room is occupied.

7. A plastic bottle of commercial strength ammonia solution for leak detection shall be provided.

8. Rooms or buildings where chlorine is stored or used shall be placarded in accordance with 875—Chapter 140, Iowa Administrative Code.

(2) Chlorine and carbon dioxide (CO₂) cylinders.

1. Chlorine gas and CO₂ cylinders shall be individually anchored with safety chains or straps.

2. Storage space shall be provided so that chlorine cylinders are not subject to direct sunlight.

3. The chlorinator shall be designed to prevent the backflow of water or moisture into the chlorine gas cylinder.

4. An automatic shutoff shall be provided to shut off the gas chlorinator and the pH control chemical pump when the recirculation pump stops.

o. Water slides.

(1) Water slide support structures shall be free of obvious structural defects.

(2) The internal surface of a flume shall be smooth and continuous for its entire length.

(3) The flume shall have no sharp edges within reach of a user while the user is in the proper sliding position.

15.4(5) Showers, dressing rooms, and sanitary facilities. Swimming pool users shall have access to showers, dressing rooms, and sanitary facilities that are clean and free of debris. If a bathhouse is provided, the following shall be met:

a. Floors shall have a slip-resistant surface.

b. Floors shall provide adequate drainage to prevent standing water.

c. Olefin or other approved carpeting may be used in locker room or dressing room areas provided there is an adequate drip area between the carpeting and the shower room, toilet facilities, swimming pool, or other area where water can accumulate.

d. All lavatories, showers, and sanitary facilities shall be functional.

e. Soap shall be available at each lavatory and at each indoor shower fixture.

15.4(6) Management, notifications, and records.

a. *Certified operator required.* Each facility shall employ a certified operator. One certified operator may be responsible for a maximum of three facilities. Condominium associations, apartments and homeowners associations with 25 or fewer living units are exempt from this requirement.

b. *Pool rules sign.* A legible pool rules sign shall be posted conspicuously at a minimum of two locations within the swimming pool enclosure. The sign shall include the following stipulations:

- (1) No diving in the shallow end of the swimming pool and in other areas marked "No Diving."
- (2) No rough play in or around the swimming pool.
- (3) No running on the deck.

c. *Other rules.* Management may adopt and post such other rules as it deems necessary to provide for user safety and the proper operation of the facility.

d. *"No Lifeguard" signs.* Where lifeguards are not provided whenever the pool is open, a sign shall be posted at each entry to a swimming pool or a wading pool.

(1) The sign(s) at a swimming pool shall state that lifeguards are not on duty and children under the age of 12 must be accompanied by an adult.

(2) The sign(s) at a wading pool shall state that lifeguards are not on duty and children must be accompanied by an adult.

e. *Water slide rules.* Rules and restrictions for the use of a water slide shall be posted near the slide. The rules shall address the following as applicable:

- (1) Use limits.
- (2) Attire.
- (3) Riding restrictions.
- (4) Water depth at exit.
- (5) Special rules to accommodate unique aspects of the attraction.
- (6) Special warnings about the relative degree of difficulty.

f. *Operational records.* The operator of a swimming pool shall have the swimming pool operational records for the previous 12 months at the facility and shall make these records available when requested by a swimming pool inspector. These records shall contain a day-by-day account of swimming pool operation, including:

(1) ORP and pH readings, results of pH, free chlorine or total bromine residual, cyanuric acid, total alkalinity, combined chlorine, and calcium hardness tests, and any other chemical test results.

(2) Results of microbiological analyses.

(3) Reports of complaints, accidents, injuries, and illness.

(4) Dates and quantities of chemical additions, including resupply of chemical feed systems.

(5) Dates when filters were backwashed or cleaned or when a filter cartridge was changed.

(6) Monthly ground fault circuit interrupter test results.

(7) Dates of review of material safety data sheets.

(8) If applicable, dates and results of tests of each SVRS installed at a facility.

g. *Submission of records.* An inspection agency may require a facility operator to submit to the inspection agency on a monthly basis a copy of the records of the ORP and pH readings, chemical test results and microbiological analyses. The inspection agency shall notify the facility management of this requirement in writing at least 15 days before the reports are to be submitted for the first time. The facility management shall submit the required reports to the inspection agency within 10 days after the end of each month of operation.

h. *Certificates.* Copies of certified operator certificates and copies of lifeguard, first-aid, basic water rescue, and CPR certificates for the facility staff shall be kept at the facility.

i. *Operations manual.* A permanent manual for the operation of the swimming pool shall be kept at the facility. The manual shall include instructions for routine operations at the swimming pool including, but not necessarily limited to:

- (1) Water testing procedures, including the required frequency of testing.
- (2) Maintaining the chemical supply for the chemical feed systems.
- (3) Filter backwash or cleaning.

- (4) Vacuuming and cleaning the swimming pool.
- (5) Superchlorination.
- (6) Controller sensor maintenance, where applicable.

j. Schematic drawing. A schematic drawing of the pool recirculation system shall be posted in the swimming pool filter room or shall be in the operations manual. Clear labeling of the swimming pool piping with flow direction and water status (unfiltered, treated, backwash) may be substituted for the schematic drawing.

k. Material safety data sheets. Copies of material safety data sheets (MSDS) of the chemicals used at the swimming pool shall be kept at the facility in a location known and readily accessible to facility staff with chemical-handling responsibilities. Each member of the facility staff with chemical-handling responsibilities shall review the MSDS at least annually. The facility management shall retain records of the MSDS reviews at the facility and shall make the records available upon request by a swimming pool inspector.

l. Emergency plan. The facility management shall develop a written emergency plan. The plan shall include, but may not be limited to, actions to be taken in cases of drowning, serious illness or injury, chemical-handling accidents, weather emergencies, and other serious incidents. The emergency plan shall be reviewed with the facility staff at least once a year, and the dates of review or training shall be recorded in the pool records. The written emergency plan shall be kept at the facility and shall be available to a swimming pool inspector upon request.

m. Lifeguard staffing plan. The lifeguard/program staffing plan for the facility shall be available to the swimming pool inspector at the facility. The plan shall include staffing assignments for all programs conducted at the pool.

n. Residential swimming pools used for commercial purposes. A residential swimming pool that is used for commercial purposes shall be subject to the following requirements:

(1) The owner of a residential swimming pool that is used for commercial purposes shall register the swimming pool with the department in accordance with 641—15.9(135I), except that no registration fee is required.

(2) The recirculation system of the swimming pool shall be operating whenever the swimming pool is used for commercial purposes.

(3) The owner or the owner's representative shall test the swimming pool water for the free chlorine or the total bromine residual prior to and after each commercial use of the swimming pool. The owner or the owner's representative shall test the swimming pool water for pH and cyanuric acid (if applicable) at least once in each day that the swimming pool is used for commercial purposes. The test results shall be recorded. The records shall be made available to a swimming pool inspector upon request.

(4) The owner or the owner's representative shall test the swimming pool water for total alkalinity and calcium hardness at least once in each month that the swimming pool is used for commercial purposes. The test results shall be recorded. The records shall be made available to a swimming pool inspector upon request.

(5) During commercial use of a residential swimming pool, the chlorine or bromine residual shall meet the requirements of 15.4(2) "a." The pH shall meet the requirements of 15.4(2) "b." If an alternative disinfectant is used, the residual shall be maintained as recommended by the manufacturer of the product. The operational range specified by the manufacturer for an alternative disinfectant shall be written in the pool records.

(6) The swimming pool shall be inspected at least annually by the local inspection agency. The inspection shall be limited to a review of the records and a survey of the swimming pool for sanitation and obvious safety hazards.

15.4(7) Reports. Swimming pool and spa operators shall report to the local inspection agency, within one business day of occurrence, all deaths; near drowning incidents; head, neck, and spinal cord injuries; and any injury which renders a person unconscious or requires immediate medical attention.

[ARC 7839B, IAB 6/3/09, effective 7/8/09]

641—15.5(135I) Construction and reconstruction. A swimming pool constructed or reconstructed after May 4, 2005, shall comply with the following standards. Nothing in these rules is intended to exempt swimming pools and associated structures from any applicable federal, state or local laws, rules, or ordinances. Applicable requirements may include, but are not limited to, the handicapped access and energy requirements of the state building code, the fire and life safety requirements of the state fire marshal, the rules of the department of workforce development, and the rules of the department of natural resources.

15.5(1) Construction permit.

a. Permit required. No swimming pool shall be constructed or reconstructed without the owner or a designated representative of the owner first receiving a permit from the department. Construction shall be completed within 24 months from the date the construction permit is issued unless an extension is granted in writing by the department.

b. Permit application. The owner of a proposed or existing facility or a designated representative of the owner shall apply for a construction permit on forms provided by the department. The application shall be submitted to the department at least 15 days prior to the start of construction of a new swimming pool or the reconstruction of an existing swimming pool.

c. Plan submission and fee. Three sets of plans and specifications shall be submitted with the application. A nonrefundable plan review fee for each swimming pool, leisure river, water slide, wave pool, wading pool, spray pad, zero-depth swimming pool, and multisection water recreation pool shall be remitted with the application as required in 15.12(3).

d. Notification of completion. The owner of a newly constructed or reconstructed swimming pool, or the owner's designated representative, shall notify the department in writing at least 15 business days prior to opening the swimming pool.

15.5(2) Plans and specifications.

a. Plan certification. Plans and specifications shall be sealed and certified in accordance with the rules of the engineering and land surveying examining board or the architectural examining board by an engineer or architect licensed to practice in Iowa. This requirement may be waived by the department if the project is the addition or replacement of a chemical feed system, including a disinfection system, or a simple replacement of a filter or pump or both.

If the requirement for engineering plans is waived, the owner of the facility assumes full responsibility for ensuring that the reconstruction complies with these rules and with any other applicable federal, state and local laws, rules and ordinances.

b. Content of plans. Plans and specifications submitted shall contain sufficient information to demonstrate to the department that the proposed swimming pool will meet the requirements of this chapter. The plans and specifications shall include, but may not be limited to:

(1) The name and address of the owner and the name, address, and telephone number of the architect or engineer responsible for the plans and specifications. If a swimming pool contractor applies for a construction permit, the name, address and telephone number of the swimming pool contractor shall be included.

(2) The location of the project by street address or other legal description.

(3) A site plan showing the pool in relation to buildings, streets, water and sewer service, gas service, and electrical service.

(4) Detailed scale drawings of the swimming pool and its appurtenances, including a plan view and cross sections at a scale of 3/32 inch per ft or larger. The location of inlets, overflow system components, main drains, the deck and deck drainage, the location and size of pool piping, the swimming pool ladders, stairs and deck equipment, including diving stands and boards, and fencing shall be shown.

(5) A drawing(s) showing the location, plan, and elevation of filters, pumps, chemical feeders, ventilation devices, heaters, and surge tanks; and additional drawings or schematics showing operating levels, backflow preventers, valves, piping, flow meters, pressure gauges, thermometers, the make-up water connection, and the drainage system for the disposal of filter backwash water.

(6) Plan and elevation drawings of bathhouse facilities including dressing rooms; lockers; showers, toilets and other plumbing fixtures; water supply; drain and vent systems; gas service; water heating equipment; electrical fixtures; and ventilation systems, if provided.

(7) Complete technical specifications for the construction of the swimming pool, for the swimming pool equipment and for the swimming pool appurtenances.

c. Deviation from plans. No deviation from the plans and specifications or conditions of approval shall be made without prior approval of the department.

15.5(3) General design.

a. Construction of fill and drain wading pools is prohibited.

b. Materials. Swimming pools shall be constructed of materials which are inert, stable, nontoxic, watertight, and durable.

c. Structural loading.

(1) Swimming pools shall be designed and constructed to withstand the anticipated structural loading. If maintenance of the structural integrity of the swimming pool requires specific operations or limits of operation, these shall be specified in the permanent operations manual required in 15.5(3) "*f.*"

(2) Except for aboveground swimming pools, a hydrostatic relief valve or a suitable underdrain system shall be provided.

d. Water supply. The water supplied to a swimming pool shall be from a water supply meeting the requirements of the department of natural resources for potable water.

(1) Water supplied to a swimming pool shall be discharged to the pool system through an air gap, or a reduced-pressure principle backflow device complying with AWWA C-511-97, "Reduced-Pressure Principle Backflow-Prevention Assembly."

(2) Each hose bib at a facility shall be equipped with an atmospheric vacuum breaker or a hose connection backflow preventer.

e. No part of a swimming pool recirculation system may be directly connected to a sanitary sewer. An air break or an air gap shall be provided.

f. Operations manual. The owner shall require that a permanent manual for the operation of the facility be provided. The manual shall include, but may not be limited to:

(1) Instructions for routine operations at the swimming pool including, but not necessarily limited to:

1. Filter backwash or cleaning.

2. Maintaining the chemical supply for the chemical feed systems.

3. Vacuuming and cleaning the swimming pool.

4. Swimming pool water testing procedures, including the frequency of testing.

5. Superchlorination.

6. Controller sensor maintenance and calibration, including the recommended frequency of maintenance.

(2) For each centrifugal pump, a pump performance curve plotted on an 8½" × 11" or larger sheet.

(3) For each chemical feeder, the maximum rated output listed in weight per time or volume per time units.

(4) Basic operating and maintenance instructions for swimming pool equipment that requires cleaning, adjustment, lubrication, or parts replacement, with recommended maintenance frequencies or the parameters that would indicate a need for maintenance.

g. A schematic drawing of the pool recirculation system shall be posted in the swimming pool filter room or shall be in the operations manual. Clear labeling of the swimming pool piping with flow direction and water status (unfiltered, treated, backwash) may be substituted for the schematic drawing.

h. A permanent file containing the operations and maintenance manuals for the equipment installed at the swimming pool shall be established. The file shall include a source for parts or maintenance for the equipment at the swimming pool. The file may be located in a location other than the facility, but it shall be readily available to the facility management and maintenance staff.

15.5(4) Decks.

a. Deck width. A swimming pool shall be surrounded by a deck. The deck shall be at least 6 ft wide for a Class A swimming pool, and 4 ft wide for a Class B swimming pool, and shall extend at least 4 ft beyond the diving stands, lifeguard chairs, swimming pool slides, or any other deck equipment.

b. Materials. Decks shall be constructed of stable, nontoxic, durable, and impervious materials and shall be provided with a slip-resistant surface.

c. Deck coverings. Porous, nonfibrous deck coverings may be used, subject to department approval, provided that:

(1) The covering allows drainage so that the covering and the deck underneath it do not remain wet or retain moisture.

(2) The covering is inert and will not support bacterial growth.

(3) The covering provides a slip-resistant surface.

(4) The covering is durable and cleanable.

d. Deck drainage. The deck of a swimming pool shall not drain to the pool or to the pool recirculation system except as provided in 15.5(15) "c" and 15.5(16) "b." For deck-level swimming pools ("rim flow" or "rollout" gutter), a maximum of 5 ft of deck may slope to the gutter.

e. Deck slope. The deck slope shall be at least 1/8 inch/ft and no more than 1/2 inch/ft to drain. The deck shall be designed and constructed so that there is no standing water on the deck during normal operation of the facility.

f. Surface runoff. For outdoor swimming pools, the drainage for areas outside the facility and for nondeck areas within the facility shall be designed and constructed to keep the drainage water off the deck and out of the swimming pool.

g. Carpeting. The installation of a floor covering of synthetic material may be used only in separate sunbathing, patio, or refreshment areas, except as permitted by 15.5(4) "c."

h. Hose bibs. At least one hose bib shall be provided for flushing the deck.

i. Rinse showers. If users are permitted free access between the deck and an adjacent sand play area without having to pass through a bathhouse, a rinse shower area shall be installed between the deck and the sand play area. Fences, barriers and other structures shall be installed so that users must pass through the rinse shower area when going from the sand play area to the deck.

(1) Tempered water shall be provided for the rinse shower(s).

(2) The rinse shower area shall have sufficient drainage so that there is no standing water.

(3) Foot surfaces in the rinse shower area shall be impervious and slip-resistant.

15.5(5) Recirculation.

a. Combined recirculation. Except for wading pools, two or more swimming pools may share the same recirculation system. A wading pool shall have a recirculation system separate from any other wading pool or swimming pool.

(1) The recirculation flow rate for each swimming pool shall be calculated in accordance with 15.5(5) "b." The recirculation flow rate for the system shall be at least the arithmetic sum of the recirculation flow rates of the swimming pools.

(2) The flow to each pool shall be adjustable. A flow meter shall be provided for each pool.

b. Recirculation flow rate. The recirculation flow rate shall provide for the treatment of one pool volume within:

(1) Four hours for a swimming pool with a volume of 30,000 gal or less.

(2) Six hours for a swimming pool with a volume of more than 30,000 gal.

(3) Two hours for a wave pool.

(4) Four hours for a zero-depth pool.

(5) One hour for a wading pool.

(6) One hour for a water slide plunge pool.

(7) Four hours for a leisure river.

(8) Thirty minutes for a spray pad with its own filter system.

(9) For swimming pools with skimmers, the recirculation flow rate shall be at least 30 gpm per skimmer or the recirculation flow rate defined above, whichever is greater.

The recirculation flow rate for pools not specified in 15.5(5) "b"(1) to (9) shall be determined by the department.

c. Recirculation pump. The recirculation pump(s) shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50 and shall comply with the following requirements:

(1) The pump(s) shall supply the recirculation flow rate required by 15.5(5) "b" at a TDH of at least that given in "1," "2," or "3" below, unless a lower TDH is shown by the designer to be appropriate. A valve for regulating the rate of flow shall be provided in the recirculation pump discharge piping.

1. 40 feet for vacuum filters; or
2. 60 feet for pressure sand filters; or
3. 70 feet for pressure diatomaceous earth filters or cartridge filters.

(2) For sand filter systems, the pump and filter system shall be designed so that each filter can be backwashed at a rate of at least 15 gpm/ft² of filter area.

(3) If a pump is located at an elevation higher than the pool water surface, it shall be self-priming or the piping shall be arranged to prevent the loss of pump prime when the pump is stopped.

(4) Where a vacuum filter is used, a vacuum limit control shall be provided on the pump suction line. The vacuum limit switch shall be set for a maximum vacuum of 18 in Hg.

(5) A compound vacuum-pressure gauge shall be installed on the pump suction line as close to the pump as practical. A vacuum gauge may be used for pumps with suction lift. A pressure gauge shall be installed on the pump discharge line as close to the pump as practical. Gauges shall be of such a size and located so that they may be easily read by the facility staff.

(6) On pressure filter systems, a hair and lint strainer shall be installed on the suction side of each recirculation pump. The hair and lint strainer basket shall be readily accessible for cleaning, changing, or inspection. A spare strainer basket shall be provided, except where the strainer basket has a volume of 15 gallons or more. This requirement may be waived for systems using vertical turbine pumps or pumps designed for solids handling.

d. Swimming pool water heaters.

(1) A heating coil, pipe or steam hose shall not be installed in a swimming pool.

(2) Gas-fired pool water heaters shall comply with the requirements of ANSI/AGA Z21.56-2001, ANSI/AGA Z21.56a-2004, and ANSI/AGA Z21.26b-2004. The data plate of the heater shall bear the AGA mark.

(3) Electric pool water heaters shall comply with the requirements of UL 1261 and shall bear the UL mark.

(4) A swimming pool water heater with an input of greater than 400,000 BTU/hour (117 kilowatts) shall have a water heating vessel constructed in accordance with ASME Boiler Code, Section 8. The data plate of the heater shall bear the ASME mark.

(5) A thermometer shall be installed in the piping to measure the temperature of the water returning to the pool. The thermometer shall be located so that it may be easily read by the facility staff.

(6) Combustion air shall be provided for fuel-burning water heaters as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

(7) Fuel-burning water heaters shall be vented as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

(8) Each fuel-burning water heater shall be equipped with a pressure relief valve sized for the energy capacity of the water heater.

e. Flow meters.

(1) Each swimming pool recirculation system shall be provided with a permanently installed flow meter to measure the recirculation flow rate.

(2) In a multiple pool system, a flow meter shall be provided for each pool.

(3) A flow meter shall be accurate within 5 percent of the actual flow rate between ± 20 percent of the recirculation flow rate specified in 15.5(5) "b" or the nominal recirculation flow rate specified by the designer.

(4) A flow meter shall be installed on a straight length of pipe with sufficient clearance from valves, elbows or other sources of turbulence to attain the accuracy required by 15.5(5)“e”(3). The flow meter shall be installed so that it may be easily read by facility staff, or a remote readout of the flow rate shall be installed where it may be easily read by the facility staff. The designer may be required to provide documentation that the installation meets the requirements of subparagraph (3).

f. Vacuum cleaning system.

(1) A swimming pool vacuum cleaning system capable of reaching all parts of the pool bottom shall be provided.

(2) A vacuum system may be provided which utilizes the attachment of a vacuum hose to the suction piping through a skimmer.

(3) Automatic vacuum systems may be used provided they are capable of removing debris from all parts of the swimming pool bottom.

15.5(6) Filtration. A filter shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50 and shall comply with the following requirements:

a. Pressure gauges. Each pressure filter shall have a pressure gauge on the inlet side. Gauges shall be of such a size and located so that they may be read easily by the facility staff. A differential pressure gauge that gives the difference between the inlet and outlet pressure of the filter may be used in place of a pressure gauge.

b. Air relief valve. An air relief valve shall be provided for each pressure filter.

c. Backwash water visible. Backwash water from a pressure filter shall discharge through an observable free fall, or a sight glass shall be installed in the backwash discharge line.

d. Indirect discharge required. Backwash water shall be discharged indirectly to a sanitary sewer or another point of discharge approved by the department of natural resources.

e. Rapid sand filter.

(1) The filtration rate shall not exceed 3 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

f. High-rate sand filter.

(1) The filtration rate shall not exceed 15 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

(3) If more than one filter tank is served by a pump, the designer shall demonstrate that the backwash flow rate to each filter tank meets the requirements of subparagraph (2) above, or an isolation valve shall be installed at each filter tank to permit each filter to be backwashed individually.

g. Vacuum sand filter.

(1) The filtration rate shall not exceed 15 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

(3) An equalization screen shall be provided to evenly distribute the filter influent over the surface of the filter sand.

(4) Each filter system shall have an automatic air-purging cycle.

h. Sand filter media shall comply with the filter manufacturer's specifications.

i. Diatomaceous earth filter.

(1) The filtration rate shall not exceed 1.5 gpm/ft² of effective filter area except that a maximum filtration rate of 2.0 gpm/ft² may be allowed where continuous body feed is provided.

(2) Diatomaceous earth filter systems shall have piping to allow recycling of the filter effluent during precoat.

(3) Waste diatomaceous earth shall be discharged to a sanitary sewer or other point of discharge approved by the department of natural resources. The discharge may be subject to the requirements of the local wastewater utility.

j. Cartridge filter.

(1) The filtration rate shall not exceed 0.38 gpm/ft² of filter area.

(2) A duplicate set of cartridges shall be provided.

k. Other filter systems may be used if approved by the department.

15.5(7) Piping.

a. Piping standards. Swimming pool piping shall conform to applicable nationally recognized standards and shall be specified for use within the limitations of the manufacturer's specifications. Swimming pool piping shall comply with the applicable requirements of NSF/ANSI Standard 61, "Drinking Water System Components—Health Effects." Plastic swimming pool pipe shall comply with the requirements of NSF/ANSI Standard 14, "Plastic Piping Components and Related Materials," for potable water pipe.

b. Pipe sizing. Swimming pool recirculation piping shall be sized so water velocities do not exceed 6 ft/sec for suction flow and 10 ft/sec for pressure flow. Gravity piping shall be sized in accordance with recognized engineering principles.

c. Overflow system piping. The piping for an overflow perimeter gutter system shall be designed to convey at least 125 percent of the recirculation flow rate. The piping for a skimmer system shall be designed to convey at least 100 percent of the recirculation flow rate.

d. Main drain piping. If the main drains are connected to the recirculation system, the main drains and main drain piping shall be designed to convey at least 100 percent of the recirculation flow rate.

e. Play feature circulation. Where there are attractions, such as water slides, fountains and play features, that circulate water to the swimming pool and through the main drain and overflow systems, the main drain and overflow systems and the associated piping shall be designed to accommodate the combined flow of the recirculation system and the attractions within the requirements of paragraph "b" above and the applicable requirements of 15.5(9) and 15.5(10).

15.5(8) Inlets.

a. Inlets required. Wall inlets or floor inlets, or both, shall be provided for a swimming pool. The inlets shall be adequate in design, number, location, and spacing to ensure effective distribution of treated water and the maintenance of a uniform disinfectant residual throughout the swimming pool. The designer may be required to provide documentation of adequate distribution. The department may require dye testing of a pool.

b. Wall inlet spacing. Where wall inlets are used, they shall be no more than 20 ft apart around the perimeter of the area with an inlet within 5 ft of each corner of the swimming pool.

(1) There shall be at least one inlet at each stairway or ramp leading into a swimming pool.

(2) Except for wading pools, wall inlets shall be located at least 6 inches below the design water surface.

(3) Wall inlets in pools with skimmers shall be directional flow-type inlets.

(4) Each inlet shall have a directional flow inlet fitting with an opening of 1-inch diameter or less, or a fixed fitting with openings ½ inch wide or less.

c. Floor inlets. Floor inlets shall be provided for the areas of a zero-depth swimming pool or wave pool where the water is less than 2 ft deep and may be used throughout a swimming pool in lieu of or in combination with wall inlets. Floor inlets shall be no more than 20 ft apart in the area where they are used. There shall be floor inlets within 15 ft of each wall of the swimming pool in the area where they are used. Floor inlets shall be flush with the pool floor.

15.5(9) Overflow system.

a. Skimmers. Recessed automatic surface skimmers shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50 except that an equalizer is not required for a skimmer installed in a swimming pool equipped with an automatic water level maintenance device.

(1) Skimmers may be used for swimming pools which are no more than 30 ft wide.

(2) A swimming pool shall have at least one skimmer for each 500 ft² of surface area or fraction thereof.

(3) Each skimmer shall be designed for a flow-through rate of at least 30 gpm or 3.8 gpm per lineal inch of weir, whichever is greater. The combined flow capacity of the skimmers in a swimming pool shall not be less than the total recirculation rate.

(4) Each skimmer shall have a weir that adjusts automatically to variations in water level of at least 4 inches.

(5) Each skimmer shall be equipped with a device to control flow through the skimmer.

(6) If a swimming pool is not equipped with an automatic water level maintenance device, each skimmer that is a suction outlet shall have an operational equalizer. The equalizer opening in the swimming pool shall be covered with a fitting listed by a listing agency approved by the department as meeting the requirements of the ASME standard.

(7) A skimmer pool shall have an approved handhold around the perimeter of the pool. The handhold shall be 9 inches or less above the minimum skimmer operation level.

b. Perimeter overflow gutters.

(1) A perimeter overflow gutter system is required for a swimming pool greater than 30 ft in width, except for a wave pool or a wading pool.

(2) The overflow weir shall extend completely around the swimming pool, except at stairs, ramps, or water slide flumes.

(3) The gutter shall be designed to provide a handhold and to prevent entrapment.

(4) Drop boxes, converters, return piping, or flumes used to convey water from the gutter shall be designed to convey 125 percent of the recirculation flow rate. The flow capacity of the gutter and the associated plumbing shall be sufficient to prevent backflow of skimmed water into the swimming pool.

(5) Gutter overflow systems shall be designed with an effective surge capacity within the gutter system and surge tank of not less than 1 gal/ft² of swimming pool surface area. In-pool surge may be permitted for prefabricated gutter systems, subject to the approval of the department.

c. Alternative overflow systems. Overflow systems not meeting all of the requirements in 15.5(9) "a" or 15.5(9) "b" may be used if the designer can provide documentation that the alternative overflow system will skim the pool water surface at least as effectively as a skimmer system.

15.5(10) Main drain system.

a. Main drains. Each swimming pool shall have a convenient means of draining the water from the pool for winterization and service.

b. Main drains for recirculation. If the main drain system is connected to the recirculation system, there shall be two or more main drains or a single main drain that is unblockable.

(1) Two main drains shall be at least 3 ft apart on center. If three or more main drains are installed, the distance between the drains farthest apart shall be at least 3 ft on center.

(2) Each main drain and its associated piping in a swimming pool shall be designed for the same flow rate. Multiple drains shall be plumbed in parallel, and the piping system shall be designed to equalize flow among the main drains.

(3) If one or two main drains are installed, each main drain cover/grate, sump and the associated piping shall be designed for at least 100 percent of the recirculation flow rate specified by 15.5(5) "b." If three or more main drains are installed, the combined flow rating of the cover/grates, the sumps and the associated piping shall be at least 200 percent of the recirculation flow rate. If water for water slides, fountains and play features is circulated through the main drain and overflow systems, the main drains shall be designed for the combined feature and recirculation flow.

(4) Manufactured main drain sumps shall be listed by a listing agency acceptable to the department for compliance with the ASME standard. Field fabricated sumps shall be designed in accordance with the ASME standard and shall be certified by an engineer licensed in Iowa.

(5) There shall be a control valve to adjust the flow between the main drain and the overflow system.

(6) Main drain covers. Each main drain shall be covered with a cover/grate that complies with the ASME standard.

1. The flow rating for each cover/grate shall comply with 15.5(10) "b"(3).

2. The mark of a listing agency acceptable to the department shall be permanently marked on the top surface of each manufactured cover/grate.

3. Field fabricated cover/grates shall be certified for compliance to the ASME standard by a professional engineer licensed in Iowa. A certificate of compliance shall be provided to the swimming pool owner and to the department.

4. The main drain cover/grate shall be designed to be securely fastened to the pool so that the cover/grate is not removable without tools.

c. Feature outlets. Where fully submerged outlets for play or decorative features or water slides are in the swimming pool, the outlets shall be designed in accordance with 15.5(10)“b.”

15.5(11) Disinfection.

a. Each swimming pool recirculation system approved for construction after May 4, 2005, shall be equipped with an automatic controller for maintenance of the disinfectant level in the swimming pool water. The control output of the controller to the disinfectant feed system shall be based on the continuous measurement of the ORP of the water in the swimming pool recirculation system.

b. No disinfection system designed to use di-chlor or tri-chlor shall be installed for an indoor swimming pool after May 4, 2005.

c. Disinfection system capacity. A continuous feed disinfectant system shall be provided. The disinfectant feed system shall have the capacity to deliver at least 10 mg/L chlorine or bromine equivalent based on the recirculation flow rate required in 15.5(5)“b” for an outdoor swimming pool and 4 mg/L chlorine or bromine equivalent based on the recirculation flow rate required in 15.5(5)“b” for an indoor swimming pool.

d. Feeder listing. A disinfectant feeder (except chlorine gas feed equipment) shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50.

e. Chemical feed stop. The disinfectant system shall be installed so that chemical feed is automatically and positively stopped when the recirculation flow is interrupted.

f. Gas chlorinators. Gas chlorinator facilities shall comply with applicable federal, state and local laws, rules and ordinances and the requirements below.

(1) The chlorine supply and gas feeding equipment shall be housed in a separate room or building.

1. No entrance or openable window to the chlorine room shall be to the inside of a building used other than for the storage of chlorine.

2. The chlorine room shall be provided with an exhaust system which takes its suction not more than 8 inches from the floor and discharges out of doors in a direction to minimize the exposure of swimming pool patrons to chlorine gas. The exhaust system shall be capable of producing 15 air changes per hour in the chlorine room.

3. An automatic chlorine leak detector and alarm system shall be provided in the chlorine room. The alarm system shall provide visual and audible alarm signals outside the chlorine room.

4. An air intake shall be provided near the ceiling of the chlorine room. The air intake and the exhaust system outlet shall be at least 4 ft apart.

5. The room shall have a window at least 12 inches square. The window glass shall be shatterproof.

6. The door of the chlorine enclosure shall open outward. The inside of the door shall be provided with panic hardware.

7. The chlorine room shall have adequate lighting.

8. Electrical switches for the exhaust system and for the lighting shall be outside the chlorine room and adjacent to the door, or in an adjoining room.

9. An anchoring system shall be provided so that full and empty chlorine cylinders can be individually secured.

10. Scales shall be provided for weighing the cylinders that are in use.

(2) A chlorine enclosure that is 30 inches deep or less and 72 inches wide or less and that is installed out of doors shall comply with the above requirements except:

1. An automatic chlorine leak detector is not required.

2. The enclosure shall have a window of at least 48 in².

3. The light and exhaust fan may be activated by opening the door rather than by a separate switch.

(3) The chlorinator shall be designed to prevent the backflow of water into the chlorine cylinder.

g. Solution feed. Where a metering pump is used to feed a solution of disinfectant, the disinfectant solution container shall have a capacity of at least one day's supply at the rate specified in 15.5(11)“c,” except that when the system is designed to feed directly from a 55-gal shipping container, a larger solution container is not required.

NOTE: Secondary containment must be provided when a tank larger than 55 gallons is installed for the storage of sodium hypochlorite.

h. Erosion disinfectant feeders. The storage capacity of an erosion feeder shall be at least one day's supply of disinfectant at the rate specified in 15.5(11) "c."

i. Test equipment. Test equipment complying with the following requirements shall be provided.

(1) The test equipment shall provide for the direct measurement of free chlorine and combined chlorine from 0 to 10 ppm in increments of 0.2 ppm or less over the full range, or total bromine from 0 to 20 ppm in increments of 0.5 ppm over the full range.

(2) The test equipment shall provide for the measurement of swimming pool water pH from 7.0 to 8.0 with at least five increments in that range.

(3) The test equipment shall provide for the measurement of total alkalinity and calcium hardness with increments of 10 ppm or less.

(4) The test equipment shall provide for the measurement of cyanuric acid from 30 to 100 ppm. This requirement may be waived for a facility that does not use cyanuric acid or a stabilized chlorine disinfectant.

15.5(12) pH control.

a. pH controller required. Each swimming pool recirculation system approved for construction after May 4, 2005, shall be equipped with a controller that senses the pH of the swimming pool water, and that automatically controls the operation of a metering pump for the addition of a pH control chemical or the operation of a carbon dioxide (CO₂) gas feed system.

b. pH chemical feed required. Each swimming pool shall have a metering pump for the addition of a pH control chemical to the pool recirculation system, or a carbon dioxide (CO₂) gas feed system.

c. Metering pump listing. A metering pump shall be listed by NSF or by another listing agency approved by the department as meeting the requirements of Standard 50.

d. CO₂ cylinder anchors. Where carbon dioxide (CO₂) is used as a method of pH control, an anchoring system shall be provided to individually secure full and empty CO₂ cylinders.

e. Chemical feed stop. The pH control system shall be installed so that chemical feed is automatically and positively stopped when the recirculation flow is interrupted.

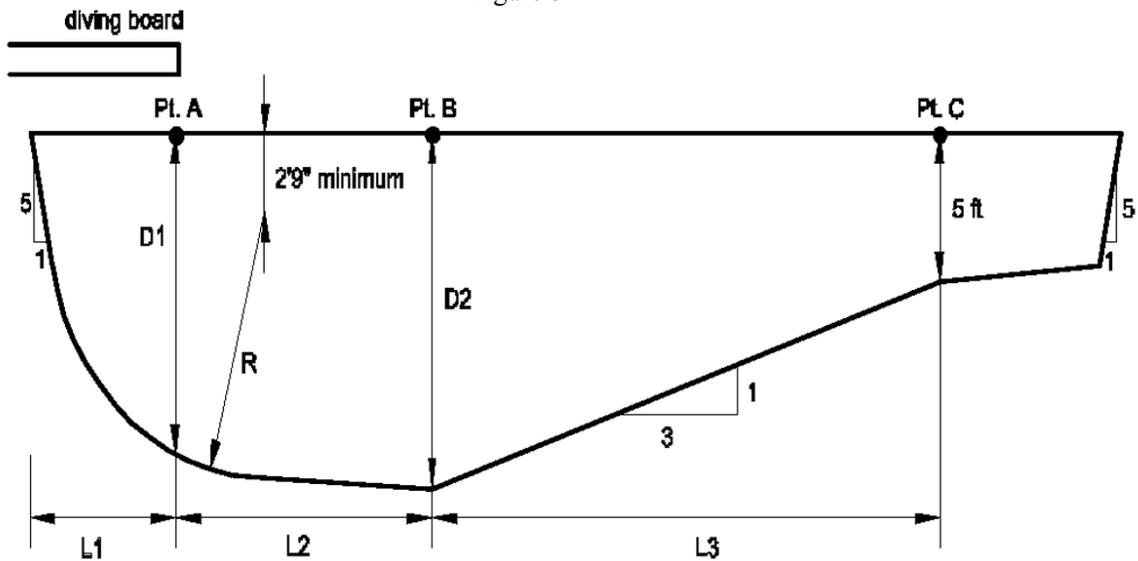
15.5(13) Safety.

a. Diving areas.

(1) Diving boards are permitted only if the diving area dimensions conform to the minimum requirements shown in Figure 3, Tables 4 and 5. Alternative diving well configurations may be used, subject to the approval of the department, but the boundaries of the diving well shall be outside the boundaries prescribed in these rules. The distances specified in Tables 4 and 5 shall be measured from the top center of the leading edge of the diving board. The reference water level shall be the midpoint of the skimmer opening for a skimmer pool or a stainless steel gutter system with surge weirs. The reference water level for a gutter pool shall be the top of the gutter weir.

(2) Where diving boards are specified that have been advertised or promoted to be "competition" diving boards, the diving area shall comply with the standards of the National Collegiate Athletic Association (NCAA) or the National Federation of State High School Associations (NFSHSA).

Figure 3



R minimum = Pool depth minus Vertical wall depth from the water line minus 3 inches.

Table 4

Diving Board Height Above Water	Maximum Board Length	Minimum Dimensions					Minimum Width of Pool		
		D1	D2	L1	L2	L3	Pt A	Pt B	Pt C
Deck level to 2/3 meter	10 ft	7 ft	8.5 ft	2.5 ft	8 ft	10.5 ft	16 ft	18 ft	18 ft
Greater than 2/3 meter to 3/4 meter	12 ft	7.5 ft	9 ft	3 ft	9 ft	12 ft	18 ft	20 ft	20 ft
Greater than 3/4 meter to 1 meter	16 ft	8.5 ft	10 ft	4 ft	10 ft	15 ft	20 ft	22 ft	22 ft
Greater than 1 meter to 3 meters	16 ft	11 ft	12 ft	6 ft	10.5 ft	21 ft	22 ft	24 ft	24 ft

Table 5

Diving Board Height Above Water	To Pool Side	To 1-Meter Board	To 3-Meter Board
Deck level to 1 meter	10 ft	8 ft	10 ft
Greater than 1 meter	11 ft	10 ft	10 ft

(3) There shall be a completely unobstructed clear distance of 13 ft above the diving board measured from the center of the front end of the board. This area shall extend at least 8 ft behind, 8 ft to each side, and 16 ft beyond the end of the diving board.

(4) Diving boards and platforms over 3 meters high are prohibited except where approved by the department.

(5) Diving boards and platforms shall have slip-resistant surfaces.

(6) Diving board supports, ladders, and guardrails.

1. Supports, platforms, and steps for diving boards shall be of substantial construction and of sufficient structural strength to safely carry the maximum anticipated loads.

2. Ladders, steps, supports, handrails and guardrails shall be of corrosion-resistant materials or shall be provided with a corrosion-resistant coating. They shall be designed to have no exposed sharp edges. Ladder steps shall have slip-resistant surfaces.

3. Handrails shall be provided at steps and ladders leading to diving boards and diving platforms. Guardrails shall be provided for diving boards and platforms which are more than 1 meter above the water. Guardrails for diving boards and platforms shall be at least 36 inches high and shall have at least one horizontal mid-bar and shall extend to the edge of the water.

b. Starting blocks and starting block installation shall meet the requirements of the competition governing body (National Collegiate Athletic Association, USA Swimming, or National Federation of State High School Associations).

c. Stairs, ladders, and recessed steps.

(1) Ladders or recessed steps shall be provided in the deep portion of a swimming pool and in the shallow portion if the vertical distance from the bottom of the swimming pool to the deck is more than 2 ft. Stairs or ramps may be used instead of ladders or recessed steps at the shallow end of the swimming pool.

(2) If a swimming pool is over 30 ft wide, recessed steps, ladders, ramps, or stairs shall be installed on each side. If a stairway centered on the shallow end wall of the swimming pool is within 30 ft of each side of the swimming pool, that end of the swimming pool shall be considered in compliance with this subrule.

(3) The foot contact surfaces of stairs, ramps, ladder rungs, and recessed steps shall be slip-resistant.

(4) Ladders.

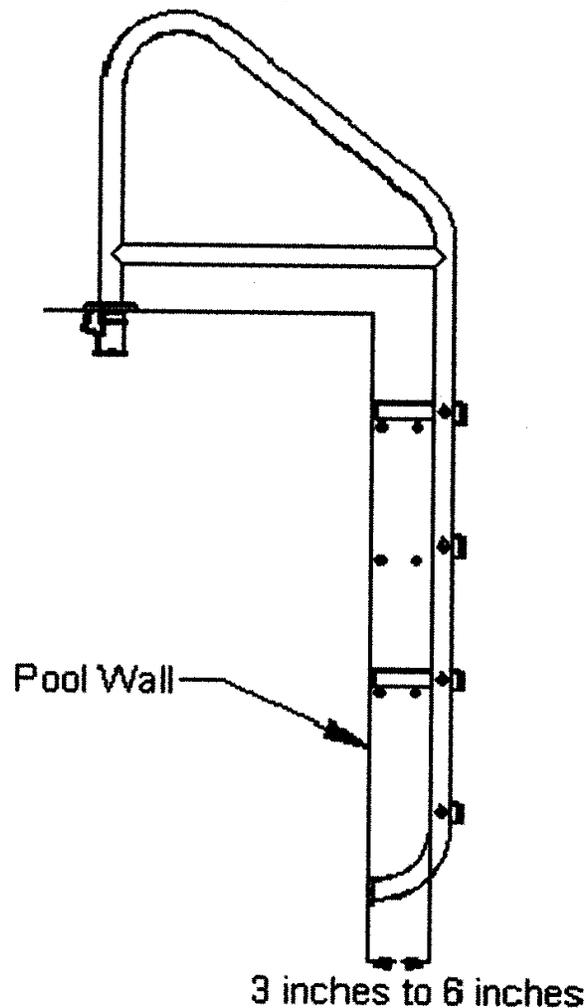
1. Ladders shall have a handrail on each side which extends from below the water surface to the top surface of the deck.

2. Ladders, treads, or supports shall be of a color contrasting with the swimming pool walls; however, stainless steel ladders may be used with stainless steel wall pools.

3. A ladder shall have a tread width of at least 16 inches and a uniform rise of 12 inches or less.

4. The distance between the swimming pool wall and the vertical rail of a ladder shall be no greater than 6 inches and no less than 3 inches. The lower end of each ladder rail shall be securely covered with a smooth nonmetallic cap. The lower end of each ladder rail shall be within 1 inch of the swimming pool wall.

Figure 4



(5) Recessed steps.

1. Recessed steps shall have a tread depth of at least 5 inches, a tread width of at least 12 inches, and a uniform rise of no more than 12 inches.

2. Each set of recessed steps shall be equipped with a securely anchored deck-level grab rail on each side.

3. Recessed steps shall drain to the pool.

(6) Stairs.

1. Stairs shall have a uniform tread depth of at least 12 inches and a uniform rise of no more than 10 inches. The area of each tread shall be at least 240 in².

2. Stairs shall be provided with at least one handrail for each 12 ft in width. Handrails shall be between 34 inches and 38 inches high, measured vertically from the line defined by the front edge of the steps.

3. A stripe at least 1 inch wide of a color contrasting with the step surface and with the swimming pool floor shall be marked at the top front edge of each tread. The stripe shall be slip-resistant.

(7) Handrails and grab rails.

1. Ladders, handrails, and grab rails shall be designed to be securely anchored so that tools are required for their removal.

2. Ladders, handrails, and grab rails shall be constructed of corrosion-resistant materials or provided with corrosion-resistant coatings. They shall have no exposed sharp edges.

d. Floor slope. The bottom of the swimming pool shall slope toward the main drain(s). The slope of the swimming pool bottom where the water is less than 5 ft deep shall not exceed 1 ft vertical in 12 ft horizontal.

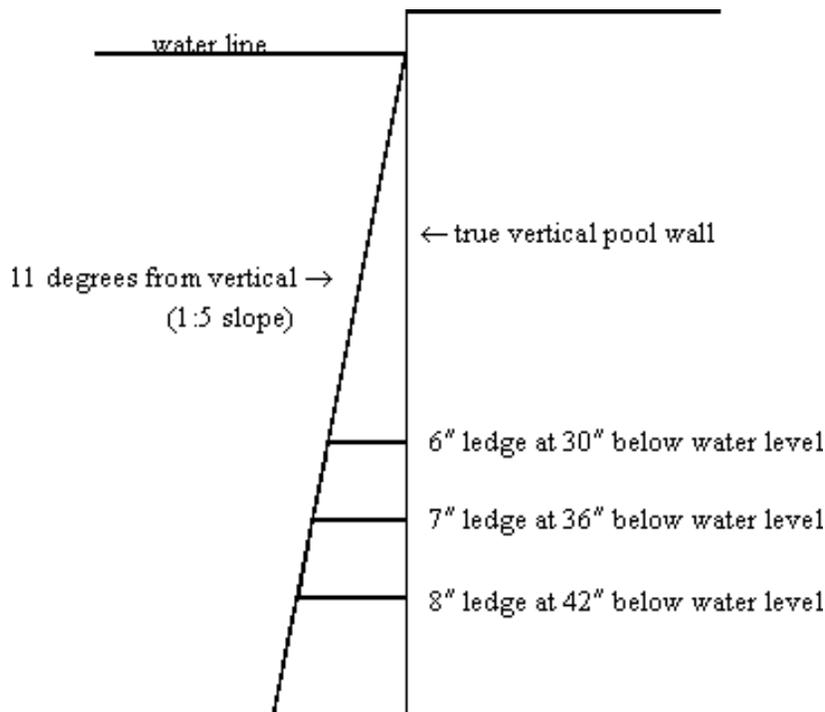
(1) Subject to the approval of the department, a swimming pool may be designed to have the change in slope (from 1:12 or less to a steeper slope) at a point where the water depth is less than 5 ft. The marking requirements of 15.5(13)“f”(3) and 15.5(13)“f”(4) shall apply and, if possible, depth markers which are clearly visible to persons in the pool shall be provided.

(2) For a wave pool, steeper slopes may be approved by the department if they are required for the proper function of the wave pool.

e. Walls.

(1) Walls in the deep section of a swimming pool shall be vertical to a water depth of at least 2.8 ft. If a transition radius is provided, it shall comply with Figure 3.

Figure 5



(2) The term “vertical” is interpreted to permit slopes not greater than 1 ft horizontal for each 5 ft of depth of side wall (11° from vertical).

(3) Ledges, when provided, shall fall within an 11° line from vertical, starting at the water surface (Figure 5). A ledge shall be no less than 4 inches wide and no more than 8 inches wide. A ledge shall have a slip-resistant surface.

f. Surface finish and markings.

(1) The swimming pool floor shall have a slip-resistant finish.

(2) The bottom and sides of the swimming pool shall be white or a light color. This does not prohibit painting or marking racing lines or turn targets.

(3) Where the slope of a swimming pool bottom in a shallow area changes from 1:12 or less to a slope greater than 1:12, or at the 5-ft depth area, the pool bottom and sides shall be marked with a stripe at least 4 inches wide in a color contrasting with the pool bottom and sides. The stripe shall be on the shallow side of the slope change or 5-ft depth area within 6 inches of the slope change or 5-ft depth area. Depending on the pool configuration, more than one stripe may be required.

(4) A float line with floats no more than 5 ft apart shall be installed on the shallow side of the stripe required in 15.5(13)“f”(3) within 12 inches of the stripe.

(5) The landing area for a swimming pool slide or a water slide which does not terminate in a separate plunge pool shall be delineated by a float line or as approved by the department.

(6) Depth markers.

1. Depth markers shall be painted or otherwise marked on the deck within 3 ft of the edge of a swimming pool. The depth of a wave pool shall also be marked on the side walls of the wave pool above the maximum static water level where the static water depth is 3 ft or more and on the deep-end wall of the wave pool.

2. Depth markers shall be located 25 ft apart or less, center to center, around the full perimeter of a swimming pool.

EXCEPTIONS: Depth markers are not required at the zero-depth end of a wading pool, wave pool, or a zero-depth swimming pool. Depth markers are not required on the deck of a plunge pool on the flume discharge end or on the exit end if stairs are used for exit.

3. The maximum depth of a swimming pool shall be marked on both sides of a swimming pool at the main drain.

4. The water depth of a swimming pool shall be marked at both ends of a float line required by 15.5(13) "f"(4).

5. In shallow water, the depth shall be marked at 1-ft depth intervals starting at one of the points specified in "3" and "4" above, if the 1-ft depth interval is less than 25 ft. The zero depth shall be used as the starting point for a zero-depth swimming pool.

6. In deep water, the words "Deep Water" may be used in place of numerals except as required in "3" above.

7. "No Diving" or equivalent wording or graphics shall be marked on the swimming pool deck within 3 ft of the edge of the swimming pool where the water is shallow and at other pool areas determined by management. The markers shall be 25 ft apart or less, center to center, around the perimeter of the area. This marking is not required at the zero-depth end of a wave pool or of a zero-depth swimming pool. "No Diving" or equivalent wording or graphics shall be marked on the deck of a leisure river in the areas where users will be permitted. The "No Diving" markers shall be within 3 ft of the edge of the leisure river at intervals not to exceed 25 ft on center.

8. Letter, number and graphic markers shall be slip-resistant, of a contrasting color from the deck and at least 4 inches in height.

9. In lieu of the requirements of "1" through "8" above, the maximum depth of a wading pool may be posted in lettering a minimum of 3 inches high at each entrance to the wading pool area and at least at one conspicuous location inside the wading pool enclosure. "No Diving" markers are not required at a wading pool.

10. The depth of a leisure river shall be posted at the entrance(s) to the leisure river in characters at least 3 inches high. The depth of the leisure river shall be marked on the side wall of the leisure river above the static water level at intervals not to exceed 50 ft on center. The depth of the leisure river shall be marked on the deck in the areas where users will be permitted. The depth markers shall be within 3 ft of the edge of the leisure river at intervals not to exceed 25 ft on center.

g. Lifeguard chairs. One elevated lifeguard chair or station shall be provided for a swimming pool with a water surface area of 2000 to 4000 ft² inclusive; two chairs shall be provided if the area is 4001 to 6000 ft²; three chairs shall be provided if the area is 6001 ft² or more. A swimming pool is not required to have more than three lifeguard chairs or stations. This requirement does not apply to wave pools, leisure rivers or wading pools.

h. Emergency equipment and facilities.

(1) If a swimming pool facility employs lifeguards, whether required by rule or not, the lifeguards shall be provided with the minimum equipment required by their training including, but not necessarily limited to, rescue tubes and personal CPR masks.

(2) A minimum of one unit of lifesaving equipment shall be provided for each 1500 ft² of water surface area or fraction thereof. The area of a swimming pool where the water is 2 ft deep or less may be subtracted from the total area for this requirement. A swimming pool is not required to have more than ten units of lifesaving equipment.

(3) A unit of lifesaving equipment consists of at least one of the following:

1. A U.S. Coast Guard-recognized ring buoy fitted with a ¼-inch diameter line with a length at least one-half the width of the pool, but no more than 60 ft; or
2. A life pole with a “shepherd’s crook,” having blunted ends with a minimum length of 8 ft; or
3. A rescue buoy which is made of a hard, buoyant plastic and is provided with molded handgrips along each side, a shoulder strap, and a towing rope between 4 and 6 ft long; or
4. A rescue tube made of a soft, strong foam material 3 inches by 6 inches by 40 inches with a molded strap providing a ring at one end and a hook at the other. Attached to the ring end shall be a 6-ft-long towline with a shoulder strap; or
5. Any other piece of rescue equipment approved by the department.

Rescue equipment identified in 15.5(13)“h”(3)“3” and 15.5(13)“h”(3)“4” above shall be used only at swimming pools where lifeguards are employed.

(4) Whenever lifeguard chairs are provided, each chair shall be equipped with at least one unit of lifesaving equipment.

(5) A standard spine board with straps and head immobilizer shall be provided at each swimming pool where lifeguards are required by rule.

i. Pool enclosures.

(1) Except for a fill and drain wading pool, a circulated wading pool that is drained when not in use, or a spray pad, a swimming pool shall be enclosed by a fence, wall, building, or combination thereof not less than 4 ft high. The enclosure shall be constructed of durable materials.

(2) A fence, wall, or other means of enclosure shall have no openings that would allow the passage of a 4-inch sphere, and shall not be easily climbable by toddlers. The distance between the ground and the top of the lowest horizontal support accessible from outside the facility, or between the two lowest horizontal supports accessible from outside the facility, shall be at least 45 inches. A horizontal support is accessible if it is on the exterior of the fence relative to the swimming pool, or if the space between the vertical members of a fence is greater than 1¼ inches.

(3) Gates and doors shall be installed in the enclosure for general access, maintenance and emergency access. At least one 36-inch-wide gate or door shall be installed for emergency access. When closed, gates and doors shall comply with the requirements of 15.5(13)“i”(1) and (2). Gates and doors shall be lockable. Except where lifeguard or structured program supervision is provided whenever the swimming pool is open, gates and doors shall be self-closing and self-latching.

(4) If a wading pool is within 50 ft of a swimming pool, the wading pool shall have a barrier at least 36 inches high separating it from the swimming pool. A barrier installed after May 4, 2005, shall have no openings that would allow the passage of a 4-inch sphere and shall not be easily climbable by toddlers. The barrier shall have at least one 36-inch-wide gate or door. Gates and doors shall be lockable. Except where lifeguard supervision is provided, gates and doors shall be self-closing and self-latching.

The department may approve alternate management of the area between the wading pool and swimming pool at facilities where lifeguards are provided whenever the pools are open. The alternate management plan shall be in writing and shall be at the facility when the pools are open.

(5) An indoor swimming pool shall be enclosed by a barrier at least 3 ft high if there are sleeping rooms, hallways, apartments, condominiums, or permanent recreation areas which are used by children and which open directly into the swimming pool area. No opening in the barrier shall permit the passage of a 4-inch sphere. The barrier shall not be easily climbable by toddlers. There shall be at least one 36-inch-wide gate or door through the barrier. Gates and doors shall be lockable. Except where lifeguard supervision is provided whenever the pool is open, gates and doors shall be self-closing and self-latching.

j. Electrical. Construction or reconstruction shall meet the requirements in Section 680 of the National Electrical Code, 70-05, as published by the National Fire Protection Association, Batterymarch Park, Quincy, MA 02269, and the following requirements:

(1) Each electrical outlet in the deck, shower and dressing rooms and the pool water treatment equipment areas shall be equipped with a properly installed ground fault circuit interrupter (GFCI) at the outlet or at the breaker serving the outlet. Electrical outlets energized through an ORP/pH controller are

not required to have a separate GFCI if the controller is equipped with a GFCI or is energized through a GFCI breaker.

(2) An underwater light circuit shall be equipped with a GFCI unless the underwater light(s) operates at 15 volts or less.

k. Lighting. Artificial lighting shall be provided at indoor swimming pools and at outdoor swimming pools which are to be used after sunset in accordance with the following:

(1) Underwater lighting of at least 60 lamp lumens/ft² or 0.5 watts/ft² of water surface area, located to provide illumination of the entire swimming pool bottom, and area lighting of at least 10 lumens/ft² or 0.6 watts/ft² of deck area.

(2) If underwater lights are not provided, overhead lighting of at least 30 lumens/ft² or 2.0 watts/ft² of swimming pool water surface area shall be provided.

l. Swimming pool slides. Swimming pool slides shall meet the requirements of the January 1, 2004, product standard of the United States Consumer Product Safety Commission (CFR Title 16, Part 1207). Swimming pool slides shall be installed in accordance with the manufacturer's recommendations.

15.5(14) Wading pools. Wading pools shall comply with the applicable provisions of 15.5(1) to 15.5(13), except as modified below.

a. A wading pool shall have at least 4 ft of deck.

b. Overflow system.

(1) Intermittent fixed weir overflow structures, including gutters, overflow fixtures, and drains at zero depth may be used. They shall have a hydraulic capacity of at least 125 percent of the recirculation flow rate. The designer shall be responsible for demonstrating that the overflow system will provide adequate skimming.

(2) If skimmers are used, there shall be at least one skimmer for every 500 ft² of water surface area or fraction thereof.

1. The recirculation flow rate shall be at least 3.8 gpm per lineal inch of skimmer weir or as required in 15.5(5) "b," whichever is greater.

2. The skimmer(s) suction line may be connected to the main drain line in lieu of an equalizer.

3. A skimmer(s) may be used in combination with overflow drains in a zero-depth wading pool.

c. Inlet system. Inlets shall be designed to uniformly distribute treated water throughout the wading pool. Wall and floor inlets or other means may be used, alone or in combination. The designer shall be responsible for demonstrating that the inlet system will provide adequate distribution of the treated water.

15.5(15) Wave pools. Wave pools shall comply with the applicable provisions of 15.5(1) to 15.5(13), except as modified below.

a. Overflow not required. Perimeter overflow gutters and skimmers are not required on the deep-end wall where the wave generation equipment is located.

b. Overflow drain at zero depth. There shall be an overflow drain or weir across the full width of the zero-depth end of the wave pool. Full width is interpreted to allow construction joints at each end of the drain. The combined length of the joints shall be no more than 10 percent of the width of the end of the pool.

The drain shall be covered with a grate designed to prevent entrapment. The grate shall be designed so that it is securely fastened to the pool floor and cannot be removed without a tool or tools.

c. Deck above zero depth. The deck above the overflow drain at the zero-depth end of the pool may slope to the overflow drain for a distance no greater than 15 ft. The deck slope shall be no greater than 1 ft vertical in 12 ft horizontal.

d. Overflow gutter or fittings. There shall be a perimeter overflow gutter or overflow fittings along both sides of the wave pool where the water is 3 ft deep or more.

(1) If a perimeter overflow gutter is used, it shall be designed to prevent entrapment during wave action. Overflow grates shall be securely fastened so they will not be dislodged by wave action.

(2) Overflow fittings need not be continuous, but they shall be spaced no more than 10 ft apart.

e. Overflow capacity. The combined hydraulic capacity of the overflow drain at zero depth and the gutter or overflow outlets shall be at least 125 percent of the recirculation flow rate.

- f. Main drains.* The main drain system shall comply with the requirements of 15.5(10).
- g. Wave generator openings.* Openings or connections between the wave pool and the wave generation equipment shall be designed to prevent entrapment of users.
- h. Side barrier.* There shall be a continuous barrier along the full length of each side of a wave pool. The barrier shall be at least 42 inches high and installed no more than 3 ft from the side of the wave pool.
- i. Emergency switches.* Emergency switches which will stop the wave action shall be provided in at least four locations on the deck of the wave pool. Switch locations shall be marked by signs or contrasting bright colors.
- j. Float line.* A wave pool shall be equipped with a float line with floats spaced no more than 5 ft apart. The float line shall be located at least 6 ft from the deep-end wall. Users shall not be permitted between the float line and the deep-end wall.

15.5(16) Zero-depth swimming pools. Zero-depth swimming pools shall comply with the applicable provisions of 15.5(1) to 15.5(13), except as modified below.

a. Overflow drain at zero depth. There shall be an overflow drain or weir across the full width of the zero-depth end of the swimming pool. Full width is interpreted to allow construction joints at each end of the drain. The combined length of the joints shall be no more than 10 percent of the width of the end of the pool.

(1) The drain shall be covered with a grate designed to prevent entrapment. The grate shall be designed so that it is not removable without a tool.

(2) The drain and its associated piping shall be designed to convey at least 50 percent of the recirculation flow rate.

b. Deck above zero depth. The deck above the overflow drain at the zero-depth end of the pool may slope to the overflow drain for a distance no greater than 15 ft. The deck slope shall be no greater than 1 ft vertical in 12 ft horizontal.

c. Perimeter overflow gutter. If a perimeter overflow gutter is provided, the gutter may be interrupted in the area where the water is less than 2 ft deep provided that:

(1) The length of the perimeter overflow gutter and overflow drain shall be at least 60 percent of the total pool perimeter.

(2) The hydraulic capacity of the perimeter overflow gutter system combined with the overflow drain shall be at least 125 percent of the recirculation flow rate.

d. Skimmers. Recessed automatic surface skimmers may be used with the overflow drain at zero depth in accordance with 15.5(9)“a.” The hydraulic capacity of the skimmer/drain system shall be at least 125 percent of the recirculation flow rate.

15.5(17) Water slides. Water slides shall comply with the applicable provisions of 15.5(1) to 15.5(13) and the following:

a. Flume construction. A water slide flume shall comply with the following:

(1) The flume shall be perpendicular to the plunge or swimming pool wall for at least 10 ft from the flume end.

(2) The flume shall be sloped no more than 1 ft vertical in 10 ft horizontal for at least 10 ft before the end of the flume.

(3) The flume shall terminate between 6 inches below and 2 inches above the design water level in the plunge pool or swimming pool.

(4) There shall be at least 5 ft between the side of the plunge pool or swimming pool and the side of the flume. Adjacent flumes shall be at least 10 ft apart on center.

(5) The inside surface of a flume shall be smooth and continuous.

(6) The flume shall be designed to ensure that users cannot be thrown out of the flume and to minimize user collisions with the sides of the flume.

(7) The flume shall have no sharp edges within reach of a user while the user is in the proper riding position.

(8) The flume path shall be designed to prevent users from becoming airborne while in the ride.

b. Water slide landing areas. The landing area for a water slide flume shall comply with the following:

(1) The water depth shall be at least 3 ft and no more than 4 ft at the end of the flume and for at least 15 ft beyond the end of the flume.

(2) The landing area floor may slope up to a minimum of 2 ft water depth subject to (1) above. The slope shall be no greater than 1 ft vertical in 12 ft horizontal.

(3) There shall be at least 20 ft between the end of the flume and any barrier or steps.

(4) If the water slide flume ends in a swimming pool, the landing area shall be divided from the rest of the swimming pool by a float line or as approved by the department.

c. Speed slides. A speed slide shall provide for the safe deceleration of the user. A run-out system or a special plunge pool entry system shall control the body position of the user relative to the slide to provide for a safe exit from the ride.

d. Decks. The deck around a water slide plunge pool shall be at least 4 ft wide, except on the side where the flume enters the pool. A walkway which is at least 4 ft wide and meets the requirements of a deck shall be provided between the plunge pool and the slide steps.

e. Alternate overflow systems. Intermittent fixed weir overflow structures may be used for a separate plunge pool if:

(1) Floor inlets are provided according to the requirements of 15.5(8) "c."

(2) The hydraulic capacity of the combined overflow structures and the appurtenant piping is at least 125 percent of the recirculation flow rate. The department may require more hydraulic capacity based on the specific design of the plunge pool system.

f. Pump reservoir. If a pump reservoir or surge tank is provided, it shall have a capacity of at least one minute of the combined recirculation and flume flow. Openings between the plunge pool and the pump reservoir or surge tank shall be designed and constructed in accordance with 15.5(10) "a" and "b."

g. Swimming pool water level. If the water slide flume ends in a swimming pool, the water level shall not be lowered more than 1 inch when the flume pump(s) is operating.

h. Suction outlets. If a fully submerged suction outlet is in a plunge pool or in a swimming pool, it shall be located away from normal water slide user traffic areas. The suction outlet system shall be designed in accordance with 15.5(10) "b."

i. Outlet covers. Rescinded IAB 6/3/09, effective 7/8/09.

j. Water slide support structure. The support structure for a water slide and for any access stairs or ramps shall be designed and constructed to withstand the anticipated structural loading, both static and dynamic, including wind forces.

k. Stairs. A stairway providing access to the top of a water slide shall be at least 2 ft wide. Stair surfaces shall be slip-resistant and easily cleanable. The stairway shall comply with the applicable requirements of state and local building codes and Occupational Safety and Health Administration requirements.

l. Alternate water slide designs. Water slides differing substantially from the standards in this subrule may be approved if the designer provides sufficient information to demonstrate to the department that the slide and its landing area can be operated safely.

15.5(18) Multisection water recreation pools. A multisection water recreation pool shall comply with the applicable provisions of 15.5(1) to 15.5(13) and the following:

a. Recirculation flow rate. The minimum recirculation flow rate for a multisection water recreation pool shall be determined by computing the recirculation flow rate for each section of the pool in accordance with 15.5(5) "b" and adding the flow rates together.

b. Water distribution. The treated water distribution system shall be designed to return treated water to the sections of the pool in proportion to the flow rates determined in "a" above.

c. Float lines. Each section of a multisection water recreation pool shall be separated from the other sections by a float line meeting the requirements of 15.5(13) "f"(4).

15.5(19) Spray pads. A spray pad shall comply with the applicable provisions of 15.5(1) through 15.5(13) and the following:

a. The surface of a spray pad shall be impervious and durable. Padding specifically designed for spray pads may be used with play features. The padding shall be water resistant or shall permit full drainage without retaining water in its structure. Walking surfaces shall be slip-resistant.

b. The spray pad surface shall slope to drain at least 1/8 inch per ft, but no more than 1/2 inch per ft. Deck or other areas outside the spray pad shall not drain into the spray pad.

c. A spray pad shall be exempt from fencing requirements (15.5(13) "i"); "No Lifeguard" sign requirements (15.4(6) "d"); safety equipment requirements (15.4(4) "f"); and depth marking requirements (15.4(4) "j"). Unless the spray pad is supervised by facility staff, a sign shall be posted near the spray pad that addresses:

- (1) No running on or around the spray pad.
- (2) No rough play.
- (3) No facility supervision. Parents are responsible for supervising their children.

Facility management may adopt and post other rules deemed necessary for user safety and the proper operation of the spray pad.

d. Spray pad drains shall be gravity outlets. At least two drains shall be provided, or a single drain that is unblockable shall be provided.

(1) The drain system and associated piping shall be designed for 125 percent of the flow into the spray pad (play feature and recirculation, as applicable).

(2) Each drain cover/grate shall be flush with the spray pad surface and shall have no opening wider than ½ inch.

(3) Each drain cover/grate shall be designed to be securely fastened to the spray pad so that the drain cover/grate is not removable without tools.

(4) Drain cover/grates that are exposed to foot traffic shall:

1. Have a slip-resistant surface; and

2. Support a 300-pound concentrated load when tested in accordance with the ASME standard, Section 3.3. Structural strength shall be verified by documentation of test results from a testing agency approved by the department or by certification by an engineer licensed in Iowa; and

3. If the drain cover is exposed to sunlight, be resistant to ultraviolet light (UV) in accordance with the ASME standard, Section 3.2.2. UV resistance shall be verified by documentation of test results from a testing agency approved by the department or by certification by an engineer licensed in Iowa.

e. Spray pads with independent treatment systems.

(1) The minimum volume of water for a spray pad shall be two minutes of the flow of the play features and the recirculation system combined.

(2) The water storage tank shall have a volume of at least 125 percent of the volume specified in (1). The tank shall be accessible for cleaning and inspection.

(3) The recirculation (treatment) system and the play feature pump and piping system shall be separate.

(4) The recirculation system inlet(s) and outlet(s) within the water storage tank shall be designed to ensure a uniform disinfectant concentration and pH level throughout the water volume of the spray pad.

(5) The play feature pump system shall be designed so that it will not operate if the recirculation system is not operating.

(6) There shall be a readily accessible sample tap in the equipment area that allows sampling of the water in the play feature piping.

f. Spray pads using water from an adjacent swimming pool or wading pool.

(1) If there is a suction outlet in the swimming pool or wading pool for the play feature pump(s), the outlet shall be designed as a main drain as specified in 15.5(10). Water velocity through the outlet cover shall be 1½ ft per sec or less.

(2) If the adjacent pool has a volume of 10,000 gallons or less, or if the spray pad water is circulated directly from the swimming pool surge tank, the spray pad pump system shall be equipped for automatic supplemental disinfection in accordance with 15.5(11), except that the disinfection capacity shall be at least one-half of the capacity specified in 15.5(11) "c"; with filtration in accordance with 15.5(6); or both.

g. Play features and sprays shall be designed and installed so that they do not create a safety hazard.

(1) Surface sprays shall be flush with the spray pad surface. Spray openings shall have a diameter of ½ inch or less. Noncircular spray openings shall have a width of ½ inch or less.

(2) Aboveground features shall not present a tripping hazard. Features shall have no sharp edges or points and no rough surfaces. Aboveground features shall be constructed of corrosion-resistant materials or provided with a corrosion-resistant coating. Accessible spray openings shall have a diameter of ½ inch or less. Noncircular accessible spray openings shall have a width of ½ inch or less.

15.5(20) *Leisure rivers.* A leisure river shall comply with the applicable requirements of 15.5(1) through 15.5(13) and the following:

a. The leisure river propulsion system and recirculation system shall be separate.

b. Intermittent fixed weir structures may be used for the overflow system. At least two separate fixed weir structures shall be used. The hydraulic capacity of the overflow system using fixed weir structures shall be at least 125 percent of the recirculation flow rate. Fixed weir structures shall be designed to prevent entrapment of leisure river users.

c. A deck as specified in 15.5(4) is not required in areas where users are not permitted. A leisure river and the area on the inside and outside perimeter of the leisure river shall be designed to ensure that lifeguard staff and emergency personnel can access any part of the leisure river quickly and to provide a sufficient hard surface area for emergency functions.

d. The depth of a leisure river shall be posted conspicuously at the entrance(s) to the leisure river in characters at least 3 inches high. The depth of the leisure river shall be marked on the side wall of the leisure river above the static water level at intervals not to exceed 50 ft on center. The depth of the leisure river shall be marked on the deck in the areas where users are permitted. The depth markers shall be within 3 ft of the edge of the leisure river at intervals not to exceed 25 ft on center.

e. “No Diving” characters or graphics shall be marked every 25 ft on center on the deck in deck areas where users are permitted.

f. At least one user egress point shall be provided for each 500 ft of leisure river length (measured at the centerline) or fraction thereof.

g. Outlets for the leisure river propulsion system shall be designed in accordance with 15.5(10)“*b.*”

15.5(21) *Showers, dressing rooms, and sanitary facilities.*

a. Facilities required. Bather preparation facilities shall be provided at each swimming pool facility except where the swimming pool facility is intended to serve living units such as a hotel, motel, apartment complex, condominium association, dormitory, subdivision, mobile home park, or resident institution.

b. Swimming pool patron load. If a bathhouse is provided, the patron load for determining the minimum sanitary fixtures (Table 6) is:

(1) One individual per 15 ft² of water surface in shallow areas.

(2) One individual per 20 ft² of water surface in deep areas with the exclusion of 300 ft² of water surface for each diving board.

(3) For each swimming pool slide, 200 ft² shall be excluded, and for each water slide which terminates in the swimming pool, 300 ft² shall be excluded in determining the patron load.

c. Bathhouses.

(1) A bathhouse shall be designed and constructed to meet the requirements of the local building ordinance. If no local ordinance is in effect, the bathhouse shall be designed to meet the requirements of the state of Iowa building code, 661—Chapter 16, Iowa Administrative Code.

(2) Bathhouse floors shall have a slip-resistant finish and shall slope at least 1/8 inch/ft to drain. Except as provided in 15.5(19)“*c*”(3), floor coverings shall comply with the requirements of 15.5(4)“*c.*”

(3) Olefin, or other approved carpeting, may be permitted in locker room or dressing room areas provided:

1. There is an adequate drip area between the carpeting and the shower room, toilet facilities, swimming pool, or other areas where water can accumulate.

2. Drip areas shall be constructed of materials as described in 15.5(4)“*b*” and 15.5(4)“*c.*”

(4) Bathhouse fixtures shall be provided in accordance with Table 6.

Table 6
Fixtures Required

Patron Load	Male				Female		
	Showers	Toilets	Urinals	Lavatories	Showers	Toilets	Lavatories
1 - 100	1	1	1	1	1	1	1
101 - 200	2	1	2	1	2	3	1
201 - 300	3	1	3	1	3	4	1
301 - 400	4	2	3	2	4	5	2
401 - 500	5	3	3	2	5	6	2
501 - 1000	6	3	4	2	6	7	2

(5) All indoor swimming pool areas, bathhouses, dressing rooms, shower rooms, and toilets shall be ventilated by natural or mechanical means to control condensation and odors.

d. Showers and lavatories.

(1) Showers shall be supplied with water at a temperature of at least 90°F and no more than 110°F and at a rate of no more than 3 gpm per shower head.

(2) Soap dispensers or bar soap trays shall be provided at each lavatory and in the showers. Glass soap dispensers are prohibited.

e. Hose bibs. At least one hose bib shall be installed within the bathhouse.

f. Storage-type hot water heaters.

(1) Gas-fired storage-type hot water heaters shall comply with the requirements of ANSI/AGA Z21.10.1-2001, or with the requirements of ANSI/AGA Z21.10.3-2001. The heater shall bear the mark of the AGA.

(2) Electric storage-type hot water heaters shall comply with the requirements of ANSI/UL 174-1996. The heater shall bear the mark of UL.

(3) Combustion air shall be provided for fuel-burning water heaters as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

(4) Fuel-burning water heaters shall be vented as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

[ARC 7839B, IAB 6/3/09, effective 7/8/09]

ADMINISTRATION

641—15.6(135I) Enforcement.

15.6(1) The department may inspect swimming pools and spas regulated by these rules and enforce these rules. A city, county or district board of health may inspect swimming pools and spas regulated by these rules and enforce these rules in accordance with agreements executed with the department pursuant to the authority of Iowa Code chapters 28E and 135I.

15.6(2) The inspection agency shall take the following steps when enforcement of these rules is necessary.

a. Owner notification. As soon as possible after the violations are noted, the inspection agency shall provide written notification to the owner of the facility that:

- (1) Cites each section of the Iowa Code or Iowa Administrative Code violated.
- (2) Specifies the manner in which the owner or operator failed to comply.
- (3) Specifies the steps required for correcting the violation.
- (4) Requests a corrective action plan, including a time schedule for completion of the plan.
- (5) Sets a reasonable time limit, not to exceed 30 days from the receipt of the notice, within which the owner of the facility must respond.

b. Corrective action plan review. The inspection agency shall review the corrective action plan and approve it or require that it be modified.

c. Failure to comply. When the owner of a swimming pool or spa fails to comply with conditions of the written notice, the inspection agency may take enforcement action in accordance with Iowa Code chapters 137 and 135I, or in accordance with local ordinances.

d. Adverse actions and the appeal process. If the department determines that the provisions of Iowa Code chapter 135I and these rules have been or are being violated, the department may withhold or revoke the registration of a swimming pool or spa, or the department or the local board of health may order that a swimming pool or spa be closed until corrective action has been taken. If the swimming pool or spa is operated without being registered, or in violation of the order of the department, the department or local inspection agency may request that the county attorney or the attorney general make an application in the name of the state to the district court of the county in which the violations have occurred for an order to enjoin the violations. This remedy is in addition to any other legal remedy available to the department.

(1) A local inspection agency may request that the department withhold or revoke the registration of a swimming pool or spa, or issue an order to close a swimming pool or spa. The request shall be in writing and shall list the violations of Iowa Code chapter 135I and these rules that have occurred or are occurring when the request is made. The local inspection agency shall provide a full accounting of the actions taken by the local inspection agency to enforce Iowa Code chapter 135I and these rules.

(2) Notice of the decision to withhold or revoke the registration for a swimming pool or spa, or an order to close a swimming pool or spa shall be delivered by restricted certified mail, return receipt requested, or by personal service. The notice shall inform the owner of the right to appeal the decision and the appeal procedures. The local inspection agency and the county attorney in the county where the swimming pool or spa is located shall be notified in writing of the decision or order.

(3) An appeal of a decision to withhold or revoke a registration or of an order to close shall be submitted by certified mail, return receipt requested, within 30 days of receipt of the department's notice. The appeal shall be sent to the Iowa Department of Public Health, Division of Environmental Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075. If such a request is made within the 30-day time period, the decision or order shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the decision or order upon satisfaction that the reason for the decision or order has been or will be removed. After the hearing, or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the decision or order. If no appeal is submitted within 30 days, the decision or order shall become the department's final agency action.

(4) Upon receipt of an appeal that meets contested case status, the appeal shall be transmitted to the department of inspections and appeals within 5 working days of receipt pursuant to the rules adopted by that department regarding the transmission of contested cases. The information upon which the revocation or withholding is based shall be provided to the department of inspections and appeals.

(5) The hearing shall be conducted in accordance with 481—Chapter 10.

(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. The proposed decision and order then becomes the department's final agency action without further proceedings 10 days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subparagraph 15.6(2) "d"(7).

(7) Any appeal to the director of the department for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within 10 days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for appeal shall state the reason for appeal.

(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

1. All pleadings, motions and rules.
2. All evidence received or considered and all other submissions by recording or transcript.
3. A statement of all matters officially noticed.

4. All questions and offers of proof, objections, and rulings thereon.
5. All proposed findings and exceptions.
6. The proposed findings and order of the administrative law judge.
- (9) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested.
- (10) It is not necessary for the owner to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department that has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.
- (11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent by certified mail, return receipt requested, or by personal service to the Iowa Department of Public Health, Division of Environmental Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.
- (12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

641—15.7(135I) Variances. A variance to these rules may be granted only by the department. A variance can be granted only if sufficient information is provided to substantiate the need for and propriety of the action.

15.7(1) Requests for variances shall be in writing and shall be sent to the local inspection agency for comment. The local inspection agency shall send the request for variance to the department within 15 business days of its receipt.

15.7(2) The granting or denial of a variance will take into consideration, but not be limited to, the following criteria:

a. Substantially equal protection of health and safety shall be provided by a means other than that prescribed in the particular rule, or

b. The degree of violation of the rule is sufficiently small so as not to pose a significant risk of injury to any individual, and the remedies necessary to alleviate this minor violation would incur substantial and unreasonable expense on the part of the person seeking a variance.

15.7(3) Decisions shall be issued in writing by the department and shall include the reasons for denial or granting of the variance. Copies of decisions shall be kept at the department, and a copy shall be sent to the contracting board of health.

15.7(4) The applicant for a variance that is denied may request a review of the denial by the director of the department. The request shall be submitted in writing within 30 days of the applicant's receipt of the department's denial of a variance request. The request for a review shall be addressed to the Iowa Department of Public Health, Office of the Director, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075. The decision of the director shall be considered the department's final agency action.

15.7(5) The applicant may petition for judicial review of the final agency action pursuant to Iowa Code chapter 17A.

641—15.8(135I) Penalties. A person violating a provision of this chapter shall be guilty of a simple misdemeanor pursuant to the authority of Iowa Code section 135I.5. Each day upon which a violation occurs constitutes a separate violation.

641—15.9(135I) Registration.

15.9(1) *Swimming pool and spa registration.* No swimming pool or spa shall be operated in the state without being registered with the department. The owner of a swimming pool or spa or the owner's designated representative shall register the swimming pool or spa before the swimming pool or spa is first used and shall renew the registration annually on or before April 30. The initial registration and

registration renewal shall be submitted on forms supplied by the department. The registration for a swimming pool or spa is valid from May 1 through the following April 30.

15.9(2) *Change in ownership.* Within 30 days of the change in ownership of a swimming pool or spa, the new owner shall furnish the department with the following information:

- a. Name and registration number of the swimming pool or spa.
- b. Name, address, and telephone number of new owner.
- c. Date the change in ownership took place.
- d. A nonrefundable fee of \$20 per swimming pool or spa.

15.9(3) *Withholding registration.* The department may withhold or revoke the registration of a swimming pool or spa pursuant to 15.6(2) "d" if an owner or the owner's designated representative has violated a provision of Iowa Code chapter 135I or a rule in this chapter.

641—15.10(135I) Training courses.

15.10(1) A training course designed to fulfill the requirements of 641—15.11(135I) shall be reviewed by the department.

15.10(2) At least 15 days prior to the course date, the course director shall submit at a minimum the following to the department:

- a. A course outline with a list of instructors and guest speakers and their qualifications.
- b. Date or dates the course is to be held.
- c. Place the course is to be held.
- d. Number of hours of instruction.
- e. Course agenda.

15.10(3) The department shall approve or disapprove the course of instruction in writing within 10 business days of receipt of the information required in 15.10(2).

15.10(4) Within 30 business days after the conclusion of the course of instruction, the course director shall furnish the department with the name and address of each person who successfully completed the course.

641—15.11(135I) Swimming pool/spa operator qualifications.

15.11(1) A person designated as a certified operator of a facility for compliance with 15.4(6) "a" and 15.51(5) "a" shall have successfully completed a CPO® certification course, an AFO certification course, a PPSO certification course, an LAFT certification course, or another course of instruction approved by the department. A copy of a current, valid CPO®, AFO, PPSO, or LAFT certificate for the certified operator shall be maintained in the pool or spa records.

15.11(2) A certified operator with a CPO® certificate, a PPSO certificate, or an LAFT certificate shall attend at least ten hours of continuing education between the original certification date and the first renewal of the certificate, and shall attend at least ten additional hours of continuing education before each subsequent renewal of the certificate. A certified operator with an AFO certificate shall attend at least six hours of continuing education between the original certification date and the first renewal of the certificate, and shall attend at least six additional hours of continuing education before each subsequent renewal of the certificate. The department shall determine the continuing education requirements for a certified operator training course that is approved after May 4, 2005. Proof of continuing education shall be kept with certification records at the facility.

641—15.12(135I) Fees.

15.12(1) *Registration fees.* For each swimming pool or spa, the registration fee is \$35. Registration fees are delinquent if not received by the department by April 30 or the first business day thereafter. The owner shall pay a \$25 penalty for each month or fraction thereof that the fee is late for each swimming pool or spa that is required to be registered.

15.12(2) *Registration change fees.* For each swimming pool or spa, the fee for a change of ownership, change of facility name, or other change in registration is \$20.

15.12(3) Inspection fees. The inspection agency shall bill the owner of a facility upon completion of an inspection. Inspection fees are due upon receipt of a notice of payment due.

When the swimming pool is located within the jurisdiction of a local inspection agency, the local inspection agency may establish fees needed to defray the costs of inspection and enforcement under this chapter. Inspection fees billed by a local inspection agency shall be paid to the local inspection agency or its designee.

a. Inspection fee schedule.

Table 7
Swimming Pools and Spas

Pool Type	Inspection Fee
Swimming pool or leisure river, surface area less than 1500 ft ²	\$170
Swimming pool or leisure river, surface area 1500 ft ² or greater	\$270
Wave pool	\$270
Water slide and plunge pool	\$270
Spa	\$170
Wading pool less than or equal to 500 ft ²	\$50
Wading pool greater than 500 ft ²	\$90
Residential swimming pool used for commercial purposes	\$50

Table 8
Water Slides

	Inspection Fee
Each additional water slide into a plunge pool	\$75
Water slide into a swimming pool	\$175
Each additional water slide into a swimming pool	\$75

b. Multipool facilities. If more than one pool (swimming pool, water slide, wave pool, wading pool, or spa) is located within a fenced compound or a building, the inspection fee for the pools in the fenced compound or building shall be reduced by 10 percent. This reduction does not apply to the fees specified in Table 8.

c. Special inspection fee. When an inspection agency determines that a special inspection is required, i.e., a follow-up inspection or an inspection generated by complaints, the inspection agency may charge a special inspection fee which shall be based on the actual cost of providing the inspection.

d. Penalty. Unpaid inspection fees will be considered delinquent 45 days after the date of the bill. A penalty of \$30 per month or fraction thereof that the payment is delinquent will be assessed to the owner for each pool inspected.

15.12(4) Plan review fees.

a. New construction. A plan review fee as specified in Tables 9, 10 and 11 shall be submitted with a construction permit application for each body of water in a proposed facility. If two or more pools share a common recirculation system as specified in 15.5(5)“a,” the plan review fee shall be 25 percent less than the total plan review fee required by Tables 9, 10 and 11.

Table 9
Swimming Pools, Wading Pools and Wave Pools

Swimming Pool Area (ft ²)	Plan Review Fee
less than 500	\$165
500 to 999	\$275
1000 to 1999	\$385
2000 to 3999	\$550*
4000 and greater	\$825*

*This may include one water slide.

Table 10
Water Slides

Description	Plan Review Fee
Water slide and dedicated plunge pool	\$550
Each additional water slide into a plunge pool or swimming pool	\$165

Table 11
Spas

Spa Volume (gal)	Plan Review Fee
less than 500	\$165
500 to 999	\$275
1000 +	\$385

b. Reconstruction. The plan review fee for reconstruction is \$250 for each swimming pool, spa or bathhouse altered in the reconstruction.

c. Penalty for construction without a permit. Whenever any work for which a permit is required has been started before a permit is issued, the plan review fee shall be 150 percent of the fee specified in 15.12(3)“a” or “b.” The department may require that construction not done in accordance with the rules be corrected before a facility is used.

EXCEPTION: After receiving a construction permit application, the department may authorize preliminary construction on a project to start before issuance of a permit. The authorization shall be in writing to the owner or the owner’s authorized representative.

15.12(5) Training fees. The course sponsor for a training course designed to fulfill the requirements of 641—15.11(135I) shall pay to the department a fee of \$20 for each person who successfully completes the course. The fee is due within 30 business days of the completion of the course.

641—15.13(135I) 28E agreements. A city, county or district board of health may apply to the department for authority to inspect swimming pools and spas and enforce these rules.

15.13(1) Application and review process. Applications shall be made to the Iowa Department of Public Health, Swimming Pool Program, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075.

15.13(2) Each application shall include, at a minimum:

a. A commitment that inspectors will meet the educational requirements of 641—15.11(135I). A person who is a registered sanitarian (R.S.) or a registered environmental health specialist (R.E.H.S.) with the National Environmental Health Association shall be considered to have met the educational requirements of subrule 15.11(2).

b. A statement of the ability of the board of health to provide inspections of all swimming pools and spas within the contracted area.

c. A statement of the ability of the board of health to follow enforcement procedures contained in subrule 15.6(2).

15.13(3) If the department approves the application, the 28E agreement shall be perpetual, subject to the conditions set forth by both parties. The agreement shall include the terms and conditions required by Iowa Code chapter 28E and any additional terms agreed to by the parties.

641—15.14(135I) Application denial or partial denial—appeal.

15.14(1) Denial or partial denial of an application shall be done in accordance with the requirements of Iowa Code section 17A.12. Notice to the applicant of denial or partial denial shall be served by restricted certified mail, return receipt requested, or by personal service.

15.14(2) Any request for appeal concerning denial or partial denial shall be submitted by the aggrieved party, in writing, to the department by certified mail, return receipt requested, within 30 days of the receipt of the department's notice. The address is Iowa Department of Public Health, Swimming Pool Program, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075. Prior to or at the hearing, the department may rescind the denial or partial denial. If no request for appeal is received within the 30-day time period, the department's notice of denial or partial denial shall become the department's final agency action.

15.14(3) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals, pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

641—15.15 to 15.50 Reserved.

SPAS

641—15.51(135I) Spa operations. A spa shall be operated in a safe, sanitary manner and shall meet the following operational standards.

15.51(1) Filtration and recirculation.

a. Filters. A spa shall have a filtration system in good working condition which provides water clarity in compliance with the water quality standards of subrule 15.51(2).

(1) Each filter cartridge shall be replaced with a new, unused, or cleaned and disinfected filter cartridge in accordance with the manufacturer's recommendations for pressure rise at the inlet of the filter, but at least once a month. If a functioning pressure gauge is not present at the filter inlet, the filter cartridge(s) shall be replaced whenever the spa is drained and at least every two weeks. Filter cartridge replacements shall be recorded in the spa records.

(2) Each sand filter serving a spa shall be opened at least annually and the sand media examined for grease buildup, channeling and other deficiencies. The sand shall be cleaned and disinfected before the filter is put back into service. The annual inspection shall be recorded in the spa records.

(3) Each diatomaceous earth filter serving a spa shall be dismantled, and the filter socks and the interior of the filter shall be cleaned and disinfected at least annually. The annual cleaning shall be recorded in the spa records.

(4) The recirculation system shall have an operating pressure gauge located in front of the filter if it is a pressure filter system. A vacuum filter system shall have a vacuum gauge located between the filter and the pump.

b. The recirculation system for a spa shall treat one spa volume of water in 30 minutes or less.

c. Continuous operation required. Pumps, filters, disinfectant feeders, flow indicators, gauges, and all related components of the spa water recirculation system shall be operated continuously whenever the spa contains water, except for cleaning or servicing.

d. Inlets. The recirculation system shall have inlets adequate in design, number, location, and spacing to ensure effective distribution of treated water and maintenance of uniform disinfectant residual throughout the spa.

e. Skimmers. A spa shall have at least one skimmer.

(1) Each skimmer shall have a self-adjusting weir in place and operational.

(2) Each skimmer shall have an easily removable basket or screen upstream from any valve.

f. Wastewater. Wastewater and backwash water from a spa shall be discharged through an air break or an air gap.

g. Water supply. The water supplied to a spa shall be from a water supply meeting the requirements of the department of natural resources for potable water.

(1) Water supplied to a spa shall be discharged to the spa system through an air gap or a reduced-pressure principle backflow device meeting AWWA C-511-97, "Reduced-Pressure Principle Backflow-Prevention Assembly."

(2) Each hose bib at a facility shall be equipped with an atmospheric vacuum breaker or a hose connection backflow preventer.

h. Spa water heaters.

(1) Electric water heaters shall bear the seal of UL.

(2) Gas-fired water heaters shall bear the seal of the AGA and shall be equipped with a pressure relief valve.

(3) Fuel-burning water heaters shall be vented to the outside, in accordance with the Iowa state plumbing code.

(4) Each indoor swimming pool equipment room with fuel-burning water heating equipment shall have one or more openings to the outside of the room for the provision of combustion air.

15.51(2) Water quality and testing.

a. Disinfection.

(1) Spa water shall have a free chlorine residual of at least 2.0 ppm and no greater than 8.0 ppm, or a total bromine residual of at least 4.0 ppm and no greater than 18 ppm when the spa is open for use, except as given in Table 12.

(2) A spa shall be closed if the free chlorine is measured to be less than 1.0 ppm or the total bromine is measured to be less than 2.0 ppm.

(3) The spa shall be closed if a free chlorine measurement exceeds 8.0 ppm or if the total bromine measurement exceeds 18 ppm, except as given in Table 12.

(4) If an ORP controller with a readout meeting the requirements of 15.51(2) "*f*"(4) is installed on the spa system, the spa water shall have an ORP of at least 700 mV, but no greater than 880 mV, except as given in Table 12. The spa shall be closed if the ORP is less than 650 mV or greater than 880 mV.

(5) The spa shall be closed if the cyanuric acid concentration in the spa water exceeds 80 ppm. The spa may be reopened when the cyanuric acid concentration is 40 ppm or less.

(6) No cyanuric acid shall be added to an indoor spa after May 4, 2005, except through an existing chemical feed system designed to deliver di-chlor or tri-chlor. No cyanuric acid in any form shall be added to an indoor spa after June 30, 2008.

Table 12

Preferred Operating Range			Acceptable Operating Range		
ORP (mV)	Free Cl (ppm)	Total Br (ppm)	ORP (mV)	Free Cl (ppm)	Total Br (ppm)
700-880	2.0-8.0	4.0-18.0	700-880	1.0-1.8	2.0-3.5
			650-700 [#]	2.0-8.0	4.0-18.0
			650-700 [†]	8.2-10.0	18.5-22.0

[#] If these conditions occur on any 3 consecutive days or on any 5 days within a 7-day period, and the conditions reoccur after the spa is drained and cleaned, the facility management shall evaluate water parameters including, but not limited to, cyanuric acid, pH, combined chlorine, and phosphates (ortho- and total); and other conditions at the spa. The facility management shall modify parameters

and conditions as practical to bring the ORP to a minimum of 700 mV. The evaluation shall be completed within 30 days after the low ORP condition is known to the facility management. A written report of the evaluation shall be kept with the spa records.

† If these conditions occur on any 2 consecutive days or on any 4 days within a 7-day period, the facility management shall drain and clean the spa and notify the inspection agency. If the conditions reoccur after the spa is drained and cleaned, the facility management shall cause the conditions at the spa specified in the previous footnote and the function of the ORP equipment to be investigated by a professional pool service company. A written report detailing source water parameters, spa water parameters, spa design (including information about the installed mechanical and chemical equipment), other conditions affecting the disinfectant concentration and the ORP, and the actions taken to increase ORP relative to the disinfectant residual shall be submitted to the local inspection agency within 30 days after the low ORP condition is known to the facility management.

b. pH level. The pH of spa water shall be 7.2 to 7.8.

c. Water clarity. A spa shall be closed if the grate openings on drain fittings at or near the bottom of the spa are not clearly visible when the agitation system is off.

d. Bacteria detection.

(1) If coliform or *Pseudomonas aeruginosa* bacteria are detected in a sample taken in accordance with 15.51(2)“e”(8), the spa shall be drained, cleaned, and disinfected. The spa may reopen, and a check sample shall be taken when the spa water meets the requirements of paragraphs “a,” “b” and “c” above. If coliform or *Pseudomonas aeruginosa* bacteria are detected in the check sample, the spa shall be closed. The spa shall be drained, physically cleaned, and disinfected. The filter(s) shall be cleaned and disinfected.

1. For cartridge filters, the cartridge shall be replaced with a new, unused cartridge or a cleaned, disinfected cartridge; the filter housing shall be physically cleaned, then disinfected.

2. For sand and DE filters, the filter shall be opened and the media and components cleaned and disinfected.

The spa may reopen when no coliform or *Pseudomonas aeruginosa* bacteria are detected in a spa water sample taken when the spa water meets the requirements of paragraphs “a,” “b” and “c” above.

(2) The facility management shall notify the local inspection agency of the positive bacteriological result within one business day after the facility management has become aware of the result.

e. Test frequency. The results of the tests required below shall be recorded in the spa records.

(1) The disinfectant residual in the spa water shall be tested or the ORP of the spa water shall be checked each day before the spa is opened for use and at intervals not to exceed two hours thereafter until the spa closing time. For a spa at a condominium complex, an apartment building or a homeowners association with 25 or fewer living units, the disinfectant level in the spa water shall be tested or the ORP of the spa water shall be checked at least twice each day the spa is available for use.

If the spa is equipped with an automatic controller with a readout or local printout of ORP complying with the requirements of 15.51(2)“f”(4), the operator may make visual readings of ORP in lieu of manual testing, but the spa water shall be tested manually for disinfectant residual at least twice per day. Both ORP and disinfectant residual shall be recorded when manual testing is done. The operator shall specify in the spa records which results are from the manual tests.

(2) The pH of the spa water shall be tested each day before the spa is opened for use and at intervals not to exceed two hours thereafter until the spa closing time. For a spa at a condominium complex, an apartment building or a homeowners association with 25 or fewer living units, the pH of the spa water shall be tested at least twice each day the spa is available for use.

If the spa is equipped with an automatic controller with a readout or local printout of pH complying with the requirements of 15.51(2)“f”(5), the operator may make visual readings of pH in lieu of manual testing, but the spa water shall be tested manually for pH at least twice per day. The operator shall specify in the spa records which results are from the manual tests.

(3) The spa water temperature shall be measured whenever a manual test of the spa water is performed.

(4) If a chlorine compound is used for disinfection, the spa water shall be tested for combined chlorine at least once a day.

(5) If cyanuric acid or a stabilized chlorine is used in a spa, the spa water shall be tested for cyanuric acid at least once a day.

(6) The spa water shall be tested for total alkalinity each time the spa is refilled and at least once in each week that the spa is open for use.

(7) The spa water shall be tested for calcium hardness each time the spa is refilled.

(8) At least once in each month that a spa is open for use, a sample of the spa water shall be submitted to a laboratory certified by the department of natural resources for the determination of coliform bacteria in drinking water. The sample shall be analyzed for total coliform and *Pseudomonas aeruginosa*.

f. Test equipment.

(1) Each facility shall have functional water testing equipment for free chlorine and combined chlorine, or total bromine; pH; total alkalinity; calcium hardness; and cyanuric acid (if cyanuric acid or a stabilized chlorine is used at the facility).

(2) The test equipment shall provide for the direct measurement of free chlorine and combined chlorine from 0 to 10 ppm in increments of 0.2 ppm or less over the full range, or total bromine from 0 to 20 ppm in increments of 0.5 ppm or less over the full range.

(3) The test equipment shall provide for the measurement of spa water pH from 7.0 to 8.0 with at least five increments in that range.

(4) A controller readout used in lieu of manual disinfectant residual testing shall be a numerical analog or digital display (indicator lights are not acceptable) with an ORP scale with a range of at least 600 to 900 mV with increments of 20 mV or less.

(5) A controller readout used in lieu of manual pH testing shall be a numerical analog or digital display (indicator lights are not acceptable) with a range at least as required in 15.51(2)“f”(3) with increments of 0.2 or less over the full range.

g. Operator availability. A person knowledgeable in testing water and in operating the water treatment equipment shall be available whenever a spa is open for use.

15.51(3) Disinfection systems and cleaning.

a. Disinfectant system.

(1) Equipment for continuous feed of a chlorine or bromine compound to the spa water shall be provided and shall be operational. The equipment shall be adjustable in at least five increments over its feed capacity. Where applicable, the chemical feeder shall be listed by NSF or another listing agency approved by the department for compliance with Standard 50.

(2) The disinfectant equipment shall be capable of providing at least 10 ppm of chlorine or bromine to the spa water based on the recirculation flow rate.

(3) Equipment and piping used to apply any chemicals to the water shall be of such size, design, and material that they may be cleaned. All material used for such equipment and piping shall be resistant to the action of chemicals to be used.

(4) The use of chlorine gas is prohibited.

b. Cleaning and superchlorination.

(1) A spa shall be clean.

(2) A spa containing 500 gal of water or less shall be drained, cleaned and refilled a minimum of once a week. A spa containing over 500 gal to 2000 gal of water shall be drained, cleaned and refilled a minimum of one time every two weeks. A spa with a water volume greater than 2000 gal shall be drained, cleaned and refilled a minimum of one time every three weeks.

The department may permit a longer period between refills for spas over 2000 gal upon evaluation of the use of the spa. Such permission shall be in writing, and a copy shall be available to an inspector upon request.

(3) The inspection agency may require that a spa be drained, cleaned, and superchlorinated prior to further usage.

15.51(4) Safety.

a. Chemical safety.

(1) No disinfectant chemical, pH control chemical, algaecide, shock treatment chemical, or any other chemical that is toxic or irritating to humans shall be added to a spa over the top when the spa is occupied. If chemicals are added to the spa over the top, the spa shall not be occupied for a period of

at least 30 minutes. The operator shall test the spa water as appropriate before allowing use of the spa. The chemical addition and the test results shall be recorded in the spa records.

(2) Spa chemicals shall be stored and handled in accordance with the manufacturer's recommendations.

(3) Material safety data sheets (MSDS) for the chemicals used in the spa shall be at the facility in a location known and readily accessible to the facility staff.

(4) Chemical containers shall be clearly labeled.

(5) A chemical hazard warning sign shall be placed at the entrance of a room where chemicals are used or stored or where bulk containers are located.

b. Stairs, ladders, recessed steps, and ramps.

(1) When the top rim of a spa is more than 24 inches above the surrounding floor area, stairs or a ramp shall be provided to the top of the spa.

(2) Stairs, ladders, ladder rungs, and ramps shall be slip-resistant.

(3) Where stairs and ramps are provided, they shall be equipped with a handrail.

(4) Ladders and handrails shall be constructed of corrosion-resistant materials or provided with corrosion-resistant coatings. They shall have no exposed sharp edges.

(5) Ladders, handrails and grabrails shall be securely anchored.

c. Water temperature. Water temperature in the spa shall not exceed 104°F. The spa shall be closed if the water temperature exceeds 104°F.

(1) A thermometer shall be available to measure temperatures in the range of 80° to 120°F.

(2) Water temperature controls shall be accessible only to the spa operator.

d. Emergency telephone. Each facility where lifeguards are not provided shall have a designated emergency telephone or equivalent communication system that can be operated without coins. The communication system shall be available to users of the spa whenever the spa is open. If the emergency communication system is not located within the spa enclosure, management shall post a sign(s) indicating the location of the emergency telephone. Instructions for emergency use of the telephone shall be posted near the telephone.

e. Water level. Water level shall be maintained at the skimming level.

f. Fully submerged outlets. Each fully submerged outlet shall be designed to prevent user entrapment. A spa shall be closed if the cover/grate of a fully submerged outlet is missing or broken.

(1) For a spa constructed prior to May 13, 1998, each pump that draws water directly from a fully submerged outlet shall be connected to two or more outlets or a single outlet with an area of at least 144 in².

(2) Each fully submerged outlet shall have a cover/grate that has been tested for compliance with the requirements of the ASME standard by a testing agency approved by the department or that is certified for compliance by an engineer licensed in Iowa.

1. The cover/grate for an outlet system with a single fully submerged outlet shall have a flow rating of at least 100 percent of the maximum system flow rate. The combined flow rating for the cover/grates for an outlet system with more than one fully submerged outlet shall be at least 200 percent of the maximum system flow rate.

The maximum system flow rate is the design flow rate for the pump(s) directly connected to the outlet(s) in an outlet system. In the absence of better information, the maximum system flow rate is the capacity of the pump(s) at 50 feet TDH, based on the manufacturer's published pump curves.

2. Fully submerged outlet cover/grates shall not be removable without the use of tools.

3. Purchase records and product information that demonstrate compliance shall be maintained by the facility for at least five years from the time the cover/grate is purchased. If a field fabricated cover/grate is certified for compliance to the ASME standard by an engineer licensed in Iowa, a copy of the certification letter shall be kept at the facility for at least five years from the certification date.

(3) A spa with a single fully submerged outlet that is not unblockable and that is directly connected to a pump shall be closed if the outlet does not have a cover/grate that complies with the ASME standard.

If a spa has two or more fully submerged outlets on a single surface that are all less than 3 ft apart on center, are not unblockable, and are directly connected to a pump, the spa is considered to have a single fully submerged outlet.

(4) A spa with a single fully submerged outlet that is not unblockable and that is directly connected to a pump shall be closed if the outlet system is not equipped with a safety vacuum release system that is listed for compliance with ASME/ANSI A112.19.17-2002, "Manufactured Safety Vacuum Release Systems (SVRS) for Residential and Commercial Swimming Pool, Spa, Hot Tub, and Wading Pool Suction Systems," by a listing agency approved by the department; or another vacuum release system approved by the department.

1. Purchase records and product information that demonstrate compliance shall be maintained by the facility for at least five years from the time the SVRS is purchased or another approved system is installed.

2. An SVRS shall be installed in accordance with the manufacturer's instructions.

3. An SVRS shall be tested for proper function at the frequency recommended by the manufacturer, but at least once in each month the spa is operated. The date and result of each test shall be recorded.

(5) In lieu of compliance with subparagraphs (2), (3) and (4) above, a fully submerged outlet in a spa may be disabled with the approval of the department, except that an equalizer in a skimmer may be plugged without department approval. The management of the spa shall submit to the department information including, but not necessarily limited to:

1. The area and volume of the spa;

2. Detailed information about the inlet system, including the location of the inlets and the type of inlet fitting;

3. The number of skimmers and pipe sizes;

4. Pump information and flow rates for the outlet system; and

5. Filter type, number of filters, the size of the filter(s), and whether multiple filters are backwashed together or separately.

If the department approves the application to disable the outlet, the outlet valve shall be closed and the valve secured by removing the handle, by locking the handle closed, or by another method approved by the department. The outlet may be physically disconnected from the pump system at the option of the facility management.

g. Spa walls and floor shall be smooth and easily cleanable.

h. Decks.

(1) The deck shall have a slip-resistant surface.

(2) The deck shall be clean and free of debris.

(3) A hose bib shall be provided for flushing or cleaning of the deck.

(4) Glass objects, other than eyeglasses and safety glass doors and partitions, shall not be permitted on the deck.

i. There shall be no underwater or overhead projections or obstructions which would endanger user safety or interfere with proper spa operation.

j. Electrical.

(1) Each electrical outlet in the deck, shower room, and pool water treatment equipment areas shall be equipped with a properly installed ground fault circuit interrupter (GFCI) at the outlet or at the breaker serving the outlet. Electrical outlets energized through an ORP/pH controller are not required to have a separate GFCI if the controller is equipped with a GFCI or is energized through a GFCI breaker. Ground fault circuit interrupter receptacles and breakers shall be tested at least once in each month the spa is operating. Test dates and results shall be recorded in the spa records.

(2) There shall be no outlets located on, or within 5 ft of, the inside wall of a spa.

(3) An air switch within reach of persons in the spa and its connecting tube shall be constructed of materials that do not conduct electricity.

(4) Lighting.

1. Artificial lighting shall be provided at all spas which are to be used at night or which do not have adequate natural lighting so all portions of the spa, including the bottom and main drain, may be readily seen.

2. Underwater lights and fixtures shall be designed for their intended use. When the underwater lights operate at more than 15 volts, the underwater light circuit shall be equipped with a GFCI. When underwater lights need to be repaired, the electricity shall be shut off until repairs are completed.

3. No electrical wiring shall extend over an outdoor spa.

k. Fencing.

(1) A spa shall be enclosed by a fence, wall, building, or combination thereof not less than 4 ft high. The spa enclosure shall be constructed of durable materials. A spa may be in the same room or enclosure as another spa or a swimming pool.

(2) A fence, wall, or other means of enclosure shall have no openings that would allow the passage of a 4-inch sphere, and shall not be easily climbable by toddlers. The distance between the ground and the top of the lowest horizontal support accessible from outside the facility, or between the two lowest horizontal supports accessible from outside the facility, shall be at least 45 inches. A horizontal support is considered accessible if it is on the exterior of the fence relative to the spa, or if the gap between the vertical members of the fence is greater than 1¼ inches.

(3) At least one gate or door with an opening of at least 36 inches in width shall be provided for emergency purposes. When closed, gates and doors shall comply with the requirements of (2) above. Gates and doors shall be lockable. Except where lifeguard supervision is provided whenever the spa is open, gates and doors shall be self-closing and self-latching.

(4) If there are sleeping rooms, apartments, condominiums, or permanent recreation areas which are used by children and which open directly into the spa area, the spa shall be enclosed by a barrier at least 3 ft high. No opening in the barrier shall permit the passage of a 4-inch sphere. The barrier shall not be easily climbable by toddlers. There shall be at least one 36-inch-wide gate or door through the barrier. Gates and doors shall be lockable. Except where lifeguard supervision is provided whenever the spa is open, gates and doors provided shall be self-closing and self-latching.

l. Agitation system control. The agitation system control shall be installed out of the reach of persons in the spa. The “on” cycle for the agitation system shall be no more than ten minutes.

15.51(5) Management, notification, and records.

a. Certified operator required. Each spa facility shall employ a certified operator. One certified operator may be responsible for a maximum of three facilities.

b. Spa rules sign. A “Spa Rules” sign shall be posted near the spa. The sign shall include the following stipulations:

(1) Persons with a medical condition, including pregnancy, should not use the spa without first consulting with a physician.

(2) Anyone having a contagious disease shall not use the spa.

(3) Persons shall not use the spa immediately following exercise or while under the influence of alcohol, narcotics, or other drugs.

(4) Persons shall not use the spa alone or without supervision.

(5) Children shall be accompanied by an adult.

(6) Persons shall not use the spa longer than ten minutes.

(7) No one shall dive or jump into the spa.

(8) The maximum patron load of the spa. (The maximum patron load of a spa is one individual per 2 lineal ft of inner edge of seat or bench.)

c. Spa depth. The maximum depth of a spa shall be posted at a conspicuous location near the spa in numerals or letters at least 3 inches high.

d. Glass prohibited. Glass objects other than eyeglasses, safety glass doors, and partitions shall not be permitted in a spa enclosure.

e. Operational records. The operator of a spa shall have the spa operational records for the previous 12 months at the facility and shall make these records available when requested by a swimming pool/spa inspector. These records shall contain a day-by-day account of spa operation, including:

- (1) ORP and pH readings, results of pH, free chlorine or total bromine residual, cyanuric acid (if used), combined chlorine, total alkalinity, and calcium hardness tests, and any other chemical test results.
- (2) Results of microbiological analyses.
- (3) Water temperature measurements.
- (4) Reports of complaints, accidents, injuries, or illnesses.
- (5) Dates and quantities of chemical additions, including resupply of chemical feed systems.
- (6) Dates when filters were backwashed or cleaned or a filter cartridge(s) was changed.
- (7) Draining and cleaning of spa.
- (8) Dates when ground fault circuit interrupter receptacles or circuit breakers were tested.
- (9) Dates of review of material safety data sheets.
- (10) If applicable, dates and results of tests of each SVRS installed at a facility.

f. Submission of records. An inspection agency may require facility management to submit copies of readings of ORP and pH, chemical test results and microbiological analyses to the inspection agency on a monthly basis. The inspection agency shall notify the facility management of this requirement in writing at least 15 days before the reports are to be submitted for the first time. The facility management shall submit the required reports to the inspection agency within 10 days after the end of each month of operation.

g. Operations manual. A permanent manual for operation of a spa shall be at the facility. The manual shall include instructions for routine operations at the spa including, but not necessarily limited to:

- (1) Maintaining the chemical supply for the chemical feed systems.
- (2) Filter backwash or cleaning.
- (3) Water testing procedures, including the required frequency of testing.
- (4) Procedures for draining, cleaning and refilling the spa, including chemical adjustments and controller adjustments.
- (5) Controller sensor maintenance, where applicable.
- (6) Superchlorination.

h. Schematic drawing. A schematic drawing of the spa recirculation system shall be posted in the swimming pool filter room or shall be in the operations manual. Clear labeling of the spa piping with flow direction and water status (unfiltered, treated, backwash) may be substituted for the schematic drawing.

i. Material safety data sheets. Copies of material safety data sheets (MSDS) for the chemicals used at the spa shall be kept at the facility in a location known and readily accessible to facility staff with chemical-handling responsibilities. Each member of the facility staff with chemical-handling responsibilities shall review the MSDS at least annually. The facility management shall retain records of the MSDS reviews at the facility and shall make the records available upon request by a swimming pool inspector.

j. Emergency plans. A written emergency plan shall be provided. The plan shall include, but may not be limited to, actions to be taken in cases of drowning, hyperthermia, serious illness or injury, chemical-handling accidents, weather emergencies, and other serious incidents. The emergency plan shall be reviewed with the facility staff at least once a year, and the dates of review or training shall be recorded. The written emergency plan shall be kept at the facility and shall be available to a swimming pool inspector upon request.

k. Temporary spas.

- (1) A person offering temporary spas for rent shall be a certified operator.
- (2) Records of temporary spas shall be maintained for one year which identify the location of all installations.
- (3) Written operational instructions shall be provided to individuals operating or leasing a spa. The instructions shall be consistent with this chapter and provide guidance in the following areas:
 1. Acceptable sources of water supply and procedure for cross-connection control—15.51(1)“g.”
 2. Methods for routine cleaning and superchlorination—15.51(3)“b.”
 3. Procedures for maintaining prescribed levels of disinfectant residual, pH, total alkalinity, clarity, and microbiological quality, and using the test kit—15.51(2)“a” to 15.51(2)“f.”

4. Procedures for maintaining temperature and operation of temperature controls—15.51(4)“c.”
5. Warning to prevent electrical hazards—15.51(4)“j.”
6. Procedures for operation of filters, including backwashing—15.51(1)“a.”
7. A warning to the renter that the renter should prevent unauthorized or accidental access to a spa when it contains water.

15.51(6) Reports. Spa operators shall report to the local inspection agency, within one working day of occurrence, all deaths; near drowning incidents; head, neck, and spinal cord injuries; and any injury which renders a person unconscious or requires immediate medical attention.

[ARC 7839B, IAB 6/3/09, effective 7/8/09]

641—15.52(135I) Construction and reconstruction. A spa constructed or reconstructed after May 4, 2005, shall comply with the following standards. Nothing in these rules is intended to exempt spas and associated structures from any applicable federal, state or local laws, rules or ordinances. Applicable requirements include, but are not limited to, the handicapped access and energy requirements of the state building code, the fire and life safety requirements of the state fire marshal, the rules of the department of workforce development, and the rules of the department of natural resources.

15.52(1) Construction permits.

a. Permit required. No spa shall be constructed or reconstructed without the owner or a designated representative of the owner first receiving a permit from the department. Construction shall be completed within 24 months from the date the construction permit is issued unless a written extension is granted by the department.

b. Permit application. The owner of a proposed or existing spa or a designated representative of the owner shall apply for a construction permit on forms provided by the department. The application shall be submitted to the department at least 15 days prior to construction of a new spa or the reconstruction of a spa.

c. Plan submission. Three sets of plans and specifications shall be submitted with the application. A nonrefundable plan review fee shall be remitted with the application for each spa as required in 15.12(4).

d. Notification of completion. The owner of a newly constructed or reconstructed facility or the owner’s designated representative shall notify the department in writing at least 15 business days prior to opening the spa.

15.52(2) Plans and specifications.

a. Plan certification. Plans and specifications shall be sealed and certified in accordance with the rules of the engineering and land surveying examining board or the architectural examining board by an engineer or architect licensed to practice in Iowa.

(1) This requirement may be waived by the department if the project is the addition or replacement of a chemical feed system, including a disinfection system, or a simple replacement of a filter or pump or both.

(2) If the requirement for engineering plans is waived, the owner of the spa assumes full responsibility for ensuring that the construction or reconstruction complies with these rules and with any other applicable federal, state and local laws, rules, and ordinances.

b. Content of plans. Plans and specifications shall contain sufficient information to demonstrate to the department that the proposed spa will meet the requirements of this chapter. The information shall include, but may not be limited to:

(1) The name and address of the owner and the name, address, and telephone number of the architect or engineer responsible for the plans and specifications. If a contractor applies for a construction permit, the name, address and telephone number of the contractor shall be included.

(2) The location of the project by street address or other legal description.

(3) A site plan showing the spa in relation to buildings, streets, any swimming pool within the same general area, water and sewer service, gas service, and electrical service.

(4) Detailed scale drawings of the spa and its appurtenances, including a plan view and cross sections at a scale of ¼ inch per foot or larger. The location of inlets, overflow system components,

main drains, deck and deck drainage, the location and size of spa piping, and the spa steps and handrails shall be shown.

(5) A drawing(s) showing the location, plan, and elevation of filters, pumps, chemical feeders, ventilation devices, and heaters, and additional drawings or schematics showing operating levels, backflow preventers, valves, piping, flow meters, pressure gauges, thermometers, the make-up water connection, and the drainage system for the disposal of filter backwash water.

(6) Plan and elevation drawings of bathhouse facilities including dressing rooms; lockers; showers, toilets and other plumbing fixtures; water supply and drain and vent systems; gas service; water heating equipment; electrical fixtures; and ventilation systems, if provided.

(7) Complete technical specifications for the construction of the spa, for the spa equipment and for the spa appurtenances.

c. Deviation from plans. No deviation from the plans and specifications or conditions of approval shall be made without prior approval of the department.

15.52(3) General design.

a. Materials. A spa shall be constructed of materials which are inert, stable, nontoxic, watertight, and durable.

b. Water depth. The maximum water depth for a general use spa shall not exceed 4 ft measured from the overflow level of the spa. The maximum depth of any seat or sitting bench shall not exceed 2 ft measured from the overflow level. A special-use spa may be deeper than 4 ft with written approval from the department.

c. Structural loading. A spa shall be designed and constructed to withstand anticipated structural loading for both full and empty conditions.

d. Distance from a swimming pool. A spa may be immediately adjacent to a swimming pool, or a minimum of 4 ft from a Class B swimming pool or 6 ft from a Class A swimming pool. The distance shall be measured from the outside edge of a ladder support or handrail on the deck, a lifeguard stand, a swimming pool slide, or a similar obstruction.

e. Water supply. The water supplied to a spa shall be from a source meeting the requirements of the department of natural resources for potable water.

(1) Water supplied to a spa shall be discharged to the spa system through an air gap or a reduced-pressure principle backflow device complying with the requirements of AWWA C-511-97, "Reduced-Pressure Principle Backflow-Prevention Assembly."

(2) Each hose bib at a facility shall be equipped with an atmospheric vacuum breaker or a hose connection backflow preventer.

f. Sewer separation required. No part of a spa recirculation system may be directly connected to a sanitary sewer. An air break or an air gap shall be provided.

g. Operations manual. The owner shall require that a permanent manual for operation of a spa be provided. The manual shall include, but may not be limited to:

(1) Instructions for routine operations at the spa including, but not necessarily limited to:

1. Filter backwash or cleaning.
2. Maintaining the chemical supply for the chemical feed systems.
3. Vacuuming and cleaning the spa.
4. Spa water testing procedures, including the frequency of testing.
5. Superchlorination.
6. Controller sensor maintenance and calibration, including the recommended frequency of maintenance.

(2) For each centrifugal pump, a pump performance curve plotted on an 8½" × 11" or larger sheet.

(3) For each chemical feeder, the maximum rated output listed in weight per time or volume per time units.

(4) Basic operating and maintenance instructions for spa equipment that requires cleaning, adjustment, lubrication, or parts replacement, with recommended maintenance frequencies or the parameters that would indicate a need for maintenance.

h. A schematic drawing of the spa recirculation system shall be posted in the spa filter room or shall be included in the operations manual. Clear labeling of the spa piping with flow direction and water status (unfiltered, treated, backwash) may be substituted for the schematic drawing.

i. A permanent file containing the operations and maintenance manuals for the equipment installed at the spa shall be established. The file shall include a source for parts or maintenance for the equipment at the spa. The file may be located in a location other than the facility, but the file shall be readily available to the facility management and maintenance staff.

15.52(4) Decks. A spa shall have a deck around at least 50 percent of the spa perimeter. The deck shall be at least 4 ft wide.

a. Deck materials. The deck shall be constructed of stable, nontoxic, and durable materials.

b. Deck drainage. The deck shall drain away from the spa at a slope of at least 1/8 inch/ft, but no more than 1/2 inch/ft to deck drains or to the surrounding ground surface. The deck shall be constructed to eliminate standing water.

c. Deck surface. The deck shall be provided with a slip-resistant, durable, and cleanable surface.

d. Deck covering. A deck covering may be used provided that:

(1) The covering allows drainage so that the covering and the deck do not remain wet or retain moisture.

(2) The covering is inert and will not support bacterial growth.

(3) The covering provides a slip-resistant surface.

(4) The covering is durable and cleanable.

e. Steps or ramp required. When the top rim of a spa is more than 24 inches above the surrounding floor area, stairs or a ramp shall be provided to the top of the spa. Stairs or a ramp shall be designed in accordance with the state building code or the building code adopted by the jurisdiction in which the spa is located.

15.52(5) Recirculation.

a. Separate recirculation required. A spa shall have a recirculation system separate from another spa or any swimming pool.

b. Recirculation flow rate. The recirculation system shall be capable of processing one spa volume of water within 30 minutes. For spas with skimmers, the recirculation flow rate shall be at least 3.8 gpm per lineal inch of skimmer weir or the flow rate required above, whichever is greater.

c. Recirculation pump. The recirculation pump(s) shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50 and shall comply with the following requirements:

(1) The pump(s) shall supply the recirculation flow rate required by 15.52(5) "b" at a TDH of at least that given in "1," "2" or "3" below, unless a lower TDH is shown by the designer to be hydraulically appropriate. A valve for regulating the rate of flow shall be provided in the recirculation pump discharge piping.

1. 40 feet for vacuum filters; or

2. 60 feet for pressure sand filters; or

3. 70 feet for pressure diatomaceous earth filters or cartridge filters.

(2) A separate pump or pumps shall be provided for the spa agitation system.

(3) For sand filter systems, the pump and filter system shall be designed so that each filter can be backwashed at a rate of at least 15 gpm/ft² of filter area.

(4) If a pump is located at an elevation higher than the spa water surface, it shall be self-priming or the piping shall be arranged to prevent the loss of pump prime when the pump is stopped.

(5) Where a vacuum filter is used, a vacuum limit control shall be provided on the pump suction line. The vacuum limit switch shall be set for a maximum vacuum of 18 in Hg.

(6) A compound vacuum-pressure gauge shall be installed on the pump suction line as close to the pump as practical. A vacuum gauge may be used for pumps with suction lift. A pressure gauge shall be installed on the pump discharge line as close to the pump as practical. Gauges shall be of such a size and located so that they may be easily read by the operator.

(7) On pressure filter systems, a hair and lint strainer shall be installed on the suction side of the recirculation pump. The hair and lint strainer basket shall be readily accessible for cleaning, changing, or inspection. A spare strainer basket shall be provided. This requirement may be waived for systems using vertical turbine pumps or pumps designed for solids handling.

d. Spa water heater.

(1) A heating coil, pipe or steam hose shall not be installed in a spa.

(2) Gas-fired spa water heaters shall comply with the requirements of ANSI/AGA Z21.56-2001, ANSI/AGA Z21.56a-2004, and ANSI/AGA Z21.26b-2004. The data plate of the heater shall bear the AGA mark.

(3) Electric spa water heaters shall comply with the requirements of UL 1261 and shall bear the UL mark.

(4) A spa water heater with an input of greater than 400,000 BTU/hour (117 kilowatts) shall have a water heating vessel constructed in accordance with ASME Boiler Code, Section 8. The data plate of the heater shall bear the ASME mark.

(5) A thermometer shall be installed in the piping to measure the temperature of the water returning to the spa. The thermometer shall be located so that it may be read easily by an operator.

(6) Combustion air shall be provided for fuel-burning water heaters as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

(7) Fuel-burning water heaters shall be vented as required by the state plumbing code, 641—Chapter 25, Iowa Administrative Code, or as required by local ordinance.

(8) Fuel-burning water heaters shall be equipped with a pressure relief valve sized for the energy capacity of the heater.

e. Flow meters.

(1) Each spa recirculation system shall be provided with a permanently installed flow meter to measure the recirculation flow rate.

(2) A flow meter shall be accurate within 5 percent of the actual flow rate between ± 20 percent of the recirculation flow rate specified in 15.52(5) "b" or the nominal recirculation flow rate specified by the designer.

(3) A flow meter shall be installed on a straight length of pipe with sufficient clearance from valves, elbows or other sources of turbulence to attain the accuracy required by 15.52(5) "e"(2). The flow meter shall be installed so that it may be easily read by the facility staff, or a remote readout of the flow rate shall be installed where it may be easily read by the staff. The designer may be required to provide documentation that the installation meets the requirements of subparagraph (2).

15.52(6) Filtration. A filter shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50 and shall comply with the following requirements:

a. Pressure gauges. Each pressure filter shall have a pressure gauge on the inlet side. Gauges shall be of such a size and located so that they may be read easily by the operator. A differential pressure gauge which gives the difference in pressure between the inlet and outlet of the filter may be used in place of a pressure gauge.

b. Air relief valves. An air relief valve shall be provided for each pressure filter.

c. Backwash water visible. Backwash water from a pressure filter shall discharge through an observable free fall, or a sight glass shall be installed in the backwash discharge line.

d. Backwash water discharge. Backwash water shall be discharged indirectly to a sanitary sewer or another point of discharge approved by the department of natural resources.

e. Rapid sand filter.

(1) The filtration rate shall not exceed 3 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

f. High-rate sand filter.

(1) The filtration rate shall not exceed 15 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

(3) If more than one filter tank is served by a pump, the designer shall demonstrate that backwash flow rate to each filter tank meets the requirements of subparagraph (2), or an isolation valve shall be installed at each filter tank to permit each filter to be backwashed individually.

g. Vacuum sand filter.

(1) The filtration rate shall not exceed 15 gpm/ft² of filter area.

(2) The backwash rate shall be at least 15 gpm/ft² of filter area.

(3) An equalization screen shall be provided to evenly distribute the filter influent over the surface of the filter sand.

(4) Each filter system shall have an automatic air-purging cycle.

h. Sand filter media shall comply with the filter manufacturer's specifications.

i. Diatomaceous earth filters.

(1) The filtration rate shall not be greater than 1.5 gpm/ft² of effective filter area except that a maximum filtration rate of 2.0 gpm/ft² may be allowed where continuous body feed is provided.

(2) Diatomaceous earth filter systems shall have piping to allow recycling of the filter effluent during precoat.

(3) Waste diatomaceous earth shall be discharged to a sanitary sewer or other point of discharge approved by the department of natural resources. The discharge may be subject to the requirements of the local waste water utility.

j. Cartridge filters.

(1) The filtration rate shall not exceed 0.38 gpm/ft².

(2) A duplicate set of cartridges shall be provided.

k. Other filter systems may be used if approved by the department.

15.52(7) Piping.

a. Piping standards. Spa piping shall conform to applicable nationally recognized standards and shall be specified for use within the limitations of the manufacturer's specifications. Spa piping shall comply with the applicable requirements of NSF/ANSI Standard 61, "Drinking Water System Components—Health Effects." Plastic pipe shall comply with the requirements of NSF/ANSI Standard 14, "Plastic Piping Components and Related Materials," for potable water pipe.

b. Pipe sizing. Spa recirculation piping shall be sized so that water velocities do not exceed 6 ft/sec for suction flow and 10 ft/sec for pressure flow.

c. Skimmer pipe capacity. The piping for the skimmer system shall be designed to convey 100 percent of the recirculation flow rate.

d. Main drain pipe capacity. The main drain piping shall be designed to convey 100 percent of the recirculation flow rate. If the spa agitation system uses the same suction piping as the recirculation system, the piping shall be designed for the combined flow within the requirements of paragraph "b" above.

e. Separate piping required. The piping from the spa agitation system pump to the spa shall be separate from the recirculation system piping.

15.52(8) Inlets.

a. Wall inlets shall be provided for a spa.

b. The inlets shall be adequate in design, number, location, and spacing to ensure effective distribution of treated water and the maintenance of a uniform disinfectant residual throughout the spa. At least two recirculation inlets shall be provided.

(1) Inlets shall be located at least 6 inches below the design water surface.

(2) Inlets shall be directional flow-type inlets. Each inlet shall have a fitting with an opening of 1 inch diameter or less.

c. Each agitation system opening shall have a fitting with an opening of 1 inch diameter or less.

15.52(9) Skimmers. A recessed automatic surface skimmer shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50, except that an equalizer is not required for a skimmer installed in a spa equipped with an automatic water level maintenance device.

a. Skimmers required. A spa shall have at least one skimmer for each 100 ft² of surface area or fraction thereof.

b. Flow-through skimmers. Each skimmer shall be designed for a flow-through rate of at least 3.8 gpm per lineal inch of weir. The combined capacity of all skimmers in a spa shall not be less than the total recirculation rate.

c. Skimmer weirs. Skimmers shall have weirs that adjust automatically to variations in water level of at least 4 inches.

d. Flow control. Skimmers shall be equipped with a device to control flow through the skimmer.

e. Equalizers. If a spa is not equipped with an automatic water level maintenance device, each skimmer shall have an operational equalizer. The equalizer opening in the spa shall be covered with a fitting listed by a listing agency approved by the department as meeting the requirements of the ASME standard.

f. The skimmer(s) shall not be connected to the agitation system.

15.52(10) Main drain system. Each spa shall have a convenient means of draining the water from the spa for service. Spa main drains may be on the sidewall of a spa near the spa bottom.

a. Suction outlets. If a spa pump is directly connected to a main drain or another fully submerged outlet, the pump shall be connected to two or more fully submerged outlets or to a single fully submerged outlet that is unblockable. The recirculation system and the agitation system may use the same fully submerged outlet(s).

(1) Two fully submerged outlets that are directly connected to one or more pumps in the same outlet system shall be at least 3 ft apart on center or on different spa surfaces. If three or more fully submerged outlets that are all directly connected to one or more pumps in the same outlet system are installed, the distance between the outlets farthest apart shall be at least 3 ft on center or the outlets shall be installed on different spa surfaces.

(2) If there is only one fully submerged outlet in an outlet system, the flow rating of the outlet cover/grate, sump and the associated piping shall be at least 100 percent of the maximum system flow rate. If two or more fully submerged outlets are installed in an outlet system, the combined flow rating of the cover/grates, the sumps and the associated piping shall be at least 200 percent of the maximum system flow rate. Multiple outlets in an outlet system shall be plumbed in parallel.

The maximum system flow rate for the recirculation system is the flow rate specified in 15.52(5) "b" or the design flow rate, whichever is greater. The maximum system flow rate for the agitation system is the specified design flow rate. If a flow rate is not specified, the maximum system flow rate shall be the flow capacity of the pump(s) at 50 feet TDH, based on the manufacturer's published pump curves.

b. Control valve. If a main drain is connected to the recirculation system, there shall be a control valve to adjust the flow between the main drain and the overflow system.

c. Main drain covers. Each main drain or other fully submerged outlet shall be covered with a cover/grate that is listed as complying with the requirements of the ASME standard by a listing agency approved by the department. A listed cover/grate shall be used in accordance with its listing.

(1) The flow rating for the cover/grate(s) shall comply with 15.52(10) "a"(2).

(2) The mark of a listing agency acceptable to the department shall be permanently marked on the top surface of each manufactured cover/grate.

(3) Field fabricated cover/grates shall be certified for compliance to the ASME standard by a professional engineer licensed in Iowa. A certificate of compliance shall be provided to the spa owner and to the department.

(4) The fully submerged outlet cover/grate shall be designed to be securely fastened to the spa so that the cover/grate is not removable without tools.

d. For outlet systems with manufactured sumps, the sumps shall be listed by a listing agency acceptable to the department for compliance with the ASME standard. Field fabricated sumps shall be designed in accordance with the ASME standard and shall be certified by an engineer licensed in Iowa.

15.52(11) Disinfection and pH control.

a. Controller required. A spa recirculation system shall be equipped with an automatic controller for maintenance of the disinfectant level and pH in the spa water. The control output of the controller to

the chemical feed systems shall be based on the continuous measurement of the ORP and the pH of the water in the spa recirculation system.

b. No disinfection system designed to use di-chlor or tri-chlor shall be installed for an indoor spa after May 4, 2005.

c. Disinfection system. A continuous feed disinfectant system shall be provided. The disinfectant feed system shall have the capacity to supply at least 10 mg/L chlorine or bromine based on the recirculation flow rate required in 15.52(5)“*b.*”

d. Disinfection feeder listing. A disinfectant feeder shall be listed by NSF or by another listing agency approved by the department as complying with the requirements of Standard 50.

e. Gas chlorine shall not be used as a disinfectant for a spa.

f. Solution feed. Where a metering pump is used to feed a solution of disinfectant, the disinfectant solution container shall have a capacity of at least one day’s supply at the rate specified in 15.52(11)“*c.*”

g. Erosion chlorine feeders. The storage capacity of an erosion feeder shall be at least one day’s supply of disinfectant at the rate specified in 15.52(11)“*c.*”

h. pH chemical system. Each spa shall have a metering pump for the addition of a pH control chemical to the spa recirculation system, or a carbon dioxide (CO₂) gas feed system. A metering pump shall be listed by NSF or another listing agency approved by the department as complying with the requirements of Standard 50.

i. Chemical feed stop. The chemical feed systems shall be designed so that chemical feed is automatically and positively stopped when the recirculation flow is interrupted.

j. Test equipment. Test equipment complying with the following requirements shall be provided.

(1) The test equipment shall provide for the direct measurement of free chlorine and combined chlorine from 0 to 10 ppm in increments of 0.2 ppm or less over the full range, or total bromine from 0 to 20 ppm in increments of 0.5 ppm over the full range.

(2) The test equipment shall provide for the measurement of spa water pH from 7.0 to 8.0 with at least five increments in that range.

(3) The test equipment shall provide for the measurement of total alkalinity and calcium hardness with increments of 10 ppm or less.

(4) The test equipment shall provide for the measurement of cyanuric acid from 30 to 100 ppm. This requirement may be waived for a facility that does not use cyanuric acid or a stabilized chlorine disinfectant.

15.52(12) Safety.

a. Spa entry. A spa shall have at least one stairway, ramp, ladder, or set of recessed steps designating a point of entry and exit for every 50 ft of perimeter or fraction thereof.

(1) Stair steps leading into a spa shall be at least 12 inches wide, the tread depth shall be no less than 10 inches, and the riser height shall be no more than 12 inches. If a bench or seat is used as a part of the stair, the first riser height from the bottom of the spa to the seat or bench shall be no more than 14 inches. Except for the first riser, the riser height shall be uniform.

1. Stair steps shall be provided with a slip-resistant surface.

2. The stair steps shall be provided with two handrails or grab rails, one on each side of the steps.

(2) Ladders.

1. Ladders shall be provided with a handrail which extends from below the water surface to the top surface of the deck on each side of the ladder.

2. Ladders shall be of a color contrasting with the spa walls.

(3) Recessed steps.

1. Recessed steps shall have a tread depth of at least 5 inches, a tread width of at least 12 inches, and a uniform rise of no more than 12 inches.

2. Recessed steps shall be provided with a handrail or with deck-level grab rails on each side of the recessed steps.

3. Recessed steps shall drain to the spa.

(4) Handrails and grab rails.

1. Ladders, handrails, and grab rails shall be designed to be securely anchored and so that tools are required for their removal.

2. Ladders, handrails, and grab rails shall be of corrosion-resistant materials, or provided with corrosion-resistant coatings. They shall have no exposed sharp edges.

b. Agitation system control. The agitation system start control shall be installed out of the reach of persons in the spa. The “on” cycle for the agitation system shall be no more than ten minutes.

c. Electrical. New construction or reconstruction shall comply with the requirements of the National Electrical Code, 70-2005, as published by the National Fire Protection Association, Batterymarch Park, Quincy, MA 02269.

d. Lighting. Artificial lighting shall be provided at indoor spas and at outdoor spas which are to be used after sunset, in accordance with the following:

(1) Underwater lighting of at least 60 lamp lumens/ft² or 0.5 watts/ft² of water surface area and area lighting of at least 10 lumens/ft² or 0.6 watts/ft² of deck area.

(2) If underwater lights are not provided, overhead lighting of at least 30 lumens/ft² or 2.0 watts/ft² of spa water surface area shall be provided.

e. Spa enclosure.

(1) A spa shall be enclosed by a fence, wall, building, or combination thereof not less than 4 ft high. The spa enclosure shall be constructed of durable materials. A spa may be in the same room or enclosure as another spa or a swimming pool.

(2) A fence, wall, or other means of enclosure shall have no openings that would allow the passage of a 4-inch sphere, and shall not be easily climbable by toddlers. The distance between the ground and the top of the lowest horizontal support accessible from the outside of the facility, or between the two lowest horizontal supports accessible from outside the facility, shall be at least 45 inches. A horizontal support is considered accessible if it is on the exterior of the fence relative to the spa, or if the gap between the vertical members of the fence is greater than 1¾ inches.

(3) At least one gate or door with an opening of at least 36 inches in width shall be provided for emergency purposes. When closed, gates and doors shall comply with the requirements of (2) above. Gates and doors shall be lockable. Except where lifeguard or structured program supervision is provided whenever the spa is open, gates and doors shall be self-closing and self-latching.

(4) For indoor spas, if there are sleeping rooms, apartments, condominiums, or permanent recreation areas used by children which open directly into the spa area, the spa shall be enclosed by a barrier at least 3 ft high. No opening in the barrier shall permit the passage of a 4-inch sphere. There shall be at least one 36-inch-wide gate or door through the barrier. Gates and doors shall be lockable. Except where lifeguard supervision is provided whenever the spa is open, gates or doors shall be self-closing and self-latching.

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^o Two or more ARCs

CHAPTERS 115 to 120
Reserved

CHAPTER 121
STANDARD FOR IMPACT RESISTANCE AND METHOD OF TESTING

[Prior to 7/29/87, Health Department[470] Ch 121]
Rescinded IAB 6/3/09, effective 7/8/09

CHAPTERS 122 and 123
Reserved

VETERANS AFFAIRS, IOWA DEPARTMENT OF[801]

Created by 1992 Iowa Acts, chapter 1140, section 8
 [Prior to 8/21/91, see Veterans Affairs Department[841]]
 [Prior to 1/6/93, see Veterans Affairs Division[613]]

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- 1.1(35,35A,35D) Definitions
- 1.2(35,35A,35D) Commission
- 1.3(35,35A) Executive director
- 1.4(35A,35D) Commandant
- 1.5(35A) Iowa Veterans Cemetery
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ARMED FORCES GRAVES REGISTRATION

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CHAPTER 1
ORGANIZATION AND PROCEDURES
[Prior to 6/21/91, see Veterans Affairs Department[841] Chs 1, 3, 5]
[Prior to 1/6/93, see Veterans Affairs Division[613] Chs 1, 3, 5]

801—1.1(35,35A,35D) Definitions. The following definitions are unique to the department of veterans affairs:

“Annual school of instruction” means annual classroom certification and recertification training sponsored by the department for county veteran service officers to meet accreditation requirements of the National Association of County Veteran Service Officers (NACVSO).

“Armed forces graves” means graves of any individuals who die during or after discharge from honorable service in the army, navy, air force, marines, merchant marines, coast guard, or as a federally activated reservist or member of the national guard, and are buried within the state of Iowa.

“Cemetery” means the Iowa Veterans Cemetery.

“Certificate of training” means a certificate provided to a county veteran service officer upon satisfactory completion of an annual school of instruction.

“Commandant” means the commandant of the Iowa Veterans Home.

“Commission” means the Iowa commission of veterans affairs.

“Commissioner” means a member of the Iowa commission of veterans affairs.

“County commission” means a county commission of veteran affairs.

“County commissioner” means a member of a county commission of veteran affairs.

“County veteran service officer” means an executive director or administrator of a county commission.

“Department” means the Iowa department of veterans affairs.

“Executive director” means the executive director of the Iowa department of veterans affairs.
[ARC 7825B, IAB 6/3/09, effective 7/8/09]

801—1.2(35,35A,35D) Commission. The commission is established and operates in accordance with Iowa Code chapter 35A.

1.2(1) Office location. The commission maintains its office at the Iowa Department of Veterans Affairs at Camp Dodge. The mailing address is: Iowa Commission of Veterans Affairs, c/o Camp Dodge, Building A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824. The telephone number is (515)242-5331 or 1-800-838-4692 (1-800-VET-IOWA).

1.2(2) Meetings and conduct of business.

a. Meetings. Regular meetings of the commission shall be held four times a year during the months of January, April, July, and September at 10 a.m. Notice of the time, place, and tentative agenda of all meetings shall be posted on the bulletin board located in the office of the governor 24 hours prior to the meeting. The agenda for each meeting shall include a reasonable time period for public comment. Special meetings shall be held pursuant to call by the chairperson. Notice of time and place shall be posted in the same manner as a regular meeting.

b. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

c. A quorum is required to carry a position.

d. Copies of minutes shall be kept on file in the office of the department.

e. In cases not covered by these rules, Robert’s Rules of Order shall govern.

f. An equal number of meetings shall be conducted at Camp Dodge and the Iowa Veterans Home.

1.2(3) Duties. The duties of the commission are as follows:

a. Organize and annually select a chairperson, a senior vice-chairperson and a junior vice-chairperson at the first meeting of each state fiscal year.

b. Supervise the commandant’s administration of commission policy for the operation and conduct of the Iowa Veterans Home as set out in rule 801—1.4(35A,35D) and 801—Chapter 10.

c. Review proposed administrative rules submitted by the department concerning the management and operation of the department. Unless the commission votes to disapprove a proposed rule on a two-thirds vote at the earlier of the next regularly scheduled meeting of the commission or a special

meeting of the commission called by the commission within 30 days of the date the proposed rule is submitted, the department may proceed to adopt the rule.

d. Advise and make recommendations to the department, the general assembly, and the governor concerning issues involving and impacting veterans in this state.

e. Advise and make recommendations to the general assembly and the governor concerning the management and operation of the department.

f. Conduct an equal number of meetings at Camp Dodge and the Iowa Veterans Home. The agenda for each meeting shall include a reasonable time period for public comment.

g. Administer the Iowa veterans trust fund pursuant to 801—Chapter 14, Iowa Administrative Code.

h. Maintain and authorize expenditures from the veterans license fee fund to fulfill the responsibilities of the commission pursuant to Iowa Code section 35A.11.

[ARC 7825B, IAB 6/3/09, effective 7/8/09]

801—1.3(35,35A) Executive director. The executive director is responsible for administering the duties of the department and the commission other than those related to the Iowa Veterans Home.

1.3(1) Office location and hours. The office of the executive director is located at Camp Dodge, Building A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824. The office is open to the public during the hours of 8 a.m. to 4:30 p.m. except Saturday, Sunday, and holidays. The telephone number is (515)242-5331 or 1-800-838-4692 (1-800-VET-IOWA).

1.3(2) Administrative staff. The executive director provides direction to administrative staff employed by the department to assist the executive director in carrying out assigned duties.

1.3(3) Investigation of applications. The executive director shall examine all applications and approve or disapprove same and make any investigation necessary to establish facts regarding veterans service status and veterans affairs data in accordance with Iowa Code chapters 35 and 35A.

1.3(4) Duties. The duties of the department are as follows:

a. Maintain and disseminate information to veterans and the public regarding facilities, benefits, and services available to veterans and their families and assist veterans and their families in obtaining such benefits and services.

b. Maintain information and data concerning the military service of Iowa veterans.

c. Assist county veteran affairs commissions established pursuant to Iowa Code chapter 35B. The department shall provide to county commissions suggested uniform benefits and administrative procedures for carrying out the functions and duties of the county commissions. The department shall also ensure compliance of county commissions with required office hours.

d. Permanently maintain the records including certified records of bonus applications for awards paid from the war orphans educational fund under Iowa Code chapter 35.

e. Collect and maintain information concerning veterans affairs.

f. Assist the United States Department of Veterans Affairs, the Iowa Veterans Home, funeral directors, and federally chartered veterans service organizations in providing information concerning veterans' service records and veterans affairs data.

g. Maintain alphabetically a permanent registry of the graves of all persons who served in the military, naval, or merchant marine forces of the United States in time of war and whose mortal remains rest in Iowa.

h. After consultation with the commission and the Iowa Association of County Veteran Service Officers, provide certification training to officers and county support staff pursuant to 2008 Iowa Acts, chapter 1130, section 3, and Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, section 4. Training provided shall include accreditation by the National Association of County Veteran Service Officers. Continuing education training shall be provided by the department to meet the requirements established by the National Association of County Veteran Service Officers and to ensure that each officer is proficient in the use of electronic mail, general computer use, and use of the Internet to access information regarding facilities, benefits, and services available to veterans and their families. The department shall provide two schools of instruction annually. At least one school each year will

provide continuing education requirements sufficient to maintain national accreditation and at least one school each year will provide accreditation training for nonaccredited officers, if needed.

- i.* Provide an annual training course for county commissioners of veteran affairs.
- j.* Establish and operate a state veterans cemetery pursuant to Iowa Code section 35A.5, subsection 10.
- k.* Authorize the sale, trade, or transfer of veterans commemorative property pursuant to Iowa Code chapter 37A and 801—Chapter 15, Iowa Administrative Code.
- l.* Adopt rules pursuant to Iowa Code chapter 17A and establish policy for the management and operation of the department. Prior to adopting rules, the department shall submit proposed rules to the commission for review pursuant to the requirements of Iowa Code section 35A.3.
- m.* Provide information requested by the commission concerning the management and operation of the department and the programs administered by the department.
- n.* Carry out the policies of the department.

[ARC 7825B, IAB 6/3/09, effective 7/8/09]

801—1.4(35A,35D) Commandant. The commandant is responsible for administering and enforcing all rules adopted by the commission pertaining to the operation of the Iowa Veterans Home.

1.4(1) Office location and hours. The office of the commandant is located in the Sheeler Building at the Iowa Veterans Home, 1301 Summit, Marshalltown, Iowa 50158-5485. The office is open to the public during the hours of 8 a.m. to 4:30 p.m. except Saturday, Sunday, and holidays. The telephone number is (515)752-1501. In cases of emergencies after hours, the commandant or designee may be reached at that telephone number.

1.4(2) Biennial report. The commandant shall make a full and detailed report biennially regarding matters pertaining to the Iowa Veterans Home in accordance with Iowa Code section 35D.17.

801—1.5(35A) Iowa Veterans Cemetery. The department shall operate and administer the Iowa Veterans Cemetery in accordance with United States Department of Veterans Affairs' standards.

1.5(1) Operation and maintenance. The cemetery shall be operated and maintained in accordance with national standards set forth in Title 38 U.S.C. Chapter 24.

1.5(2) Application for interment. The department shall provide veterans and their eligible dependents with a standardized application for interment at the cemetery. This application is available at the Iowa Veterans Cemetery, 34024 Veterans Memorial Drive, Adel, Iowa 50003-3300; the Iowa Department of Veterans Affairs, 7105 NW 70th Avenue, Camp Dodge, Building A6A, Johnston, Iowa 50131-1824; or online at www.iowava.org/vetcemetery/index.html.

1.5(3) Eligibility. The department shall make eligibility for interment determinations consistent with Title 38 U.S.C. Chapter 24. State residency shall not be considered a component of eligibility.

1.5(4) Appeal rights.

a. Final agency action. Eligibility determinations made by the cemetery director shall be the final decision of the department.

b. Judicial review. Judicial review of the department's decision may be sought in accordance with Iowa Code section 17A.19.

[ARC 7825B, IAB 6/3/09, effective 7/8/09]

801—1.6 Reserved.

ARMED FORCES GRAVES REGISTRATION

801—1.7(35A,35B) Armed forces graves registration. Armed forces graves registration shall be completed as follows:

1.7(1) Duties of the funeral director. The funeral director who contracts to inter the deceased veteran shall complete Armed Forces Graves Registration Record, Form 582-1002, in duplicate, forwarding the original and copy to the county commission.

1.7(2) Duties of the county commission. The county commission shall record the information alphabetically, and by description of location in the cemetery where the veteran is buried, in a book prescribed by the commission and kept for that purpose in the office of the county commission. The county commission shall forward the original Armed Forces Graves Registration Record to the executive director at the address provided in subrule 1.3(1).

1.7(3) Where filed. The original Armed Forces Graves Registration Record shall be filed at the office of the executive director.

1.7(4) Forms. Additional Armed Forces Graves Registration Record forms may be obtained by contacting the executive director's office in accordance with subrule 1.3(1).

This rule is intended to implement Iowa Code sections 35A.3 and 35B.19.

801—1.8 and 1.9 Reserved.

WAR ORPHANS EDUCATIONAL AID

801—1.10(35,35A) War orphans educational aid. Rescinded IAB 2/28/07, effective 1/29/07.

MERCHANT MARINE WAR BONUS

801—1.11(35) Merchant marine war bonus. The merchant marine war bonus shall be administered in accordance with 1999 Iowa Acts, chapter 180, sections 2 and 5.

1.11(1) Eligibility. This rule applies to former members of the active, oceangoing merchant marines who served during World War II at any time between December 7, 1941, and December 31, 1946, both dates inclusive, and who had maintained residence in this state for a period of at least six months immediately before entering the merchant marine service, and who were discharged under honorable conditions.

1.11(2) Application procedures. The application is available at the department of veterans affairs. The application may be submitted to the department with name, address and telephone number, along with required document DD-214.

1.11(3) Department processing and investigation.

a. The time period for filing applications shall begin on July 1, 1999.

b. The executive director of the department of veterans affairs will approve or disapprove the application.

1.11(4) Appeals procedure. Decisions of the executive director are subject to review by the commission. Applicants may appeal the decisions of the commission as provided by Iowa Code section 17A.19.

1.11(5) Office address. The office of the department of veterans affairs is located at 7105 NW 70th Avenue, Camp Dodge, Building A6A, Johnston, Iowa 50131-1824.

1.11(6) Qualified recipient and amount of payment. The former merchant marine or surviving unmarried widow or widower, child or children, mother, father, or person standing in loco parentis, in the order named and none other, of any deceased person, shall be paid and entitled to receive from moneys appropriated for that purpose the sum of \$12.50 for each month that the person was on active duty in the merchant marine service, all before December 31, 1946, not to exceed a total sum of \$500.

[ARC 7825B, IAB 6/3/09, effective 7/8/09]

801—1.12 to 1.14 Reserved.

801—1.15(35A,35B) Training for county commissions. Rescinded IAB 6/3/09, effective 7/8/09. [See 801—Chapter 7.]

These rules are intended to implement Iowa Code chapters 35 and 35A and sections 35B.6, 35B.11, 35D.1, 35D.13, 35D.16, and 35D.17.

[Filed 5/10/79, Notice 3/7/79—published 5/30/79, effective 7/5/79]

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[Filed 12/19/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed 7/24/98, Notice 1/28/98—published 8/12/98, effective 9/16/98]
[Filed emergency 12/3/99—published 12/29/99, effective 12/3/99]
[Filed emergency 1/29/07—published 2/28/07, effective 1/29/07]
[Filed ARC 7825B (Notice ARC 7659B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]

CHAPTER 7
COUNTY COMMISSIONS OF VETERAN AFFAIRS FUND AND TRAINING PROGRAM

801—7.1(35A,35B) County commissions of veteran affairs fund.

7.1(1) Purpose. 2008 Iowa Acts, chapter 1130, section 2, created the county commissions of veteran affairs fund. The purpose and legislative intent of this fund are to assist county commissions of veteran affairs in complying with legislative requirements for employing a county veteran service officer who is nationally accredited through the National Association of County Veterans Service Officers (NACVSO); who is occupied in veterans affairs service pursuant to Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, for a minimum number of hours; and who maintains an office in a location owned or leased by the county. Funding is allocated annually to counties pursuant to a standing appropriation by the general assembly to the Iowa department of veterans affairs.

7.1(2) Allocation amount. The department shall annually allocate \$10,000 to each county from the county commissions of veteran affairs fund. In order to qualify for the allocation, a county must agree to expend the allocation pursuant to Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, for the administration and maintenance of the county commission of veteran affairs office and staff and must also agree to maintain its current level of spending from the previous fiscal year. Moneys remaining in the county commissions of veteran affairs fund after the allocations have been distributed to the counties shall be used by the department to provide for a county commission of veteran affairs training program as outlined in rule 801—7.2(35A,35B). During fiscal year 2010, the department shall use account funds to arrange for an accreditation course by NACVSO to be held in this state. Following fiscal year 2010, the department shall arrange for an accreditation course by NACVSO to be held in this state when necessary.

7.1(3) Allocation report. Counties shall submit a written report to the department 30 days following the end of the fiscal year in which the allocation was received. The report shall provide an assessment of county veteran affairs services, including verification of an office and hours of employment, and documentation that the county veteran service officer is performing required duties pursuant to Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130. The allocation report shall also contain a final report on county veteran affairs expenditures for the fiscal year in which the allocation was received and the expenditure report from the previous fiscal year. Information provided in this report shall be used by the department to comply with rule 801—7.3(35A,35B).

7.1(4) Recovery of funds. The department shall be the entity charged with the recovery of county commissions of veteran affairs fund allocations from counties under the following circumstances:

a. Unauthorized use. Counties expending a portion of the allocation on items that do not provide services to veterans pursuant to Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, will be required to return the unauthorized funds to the state of Iowa.

b. Maintenance of effort. Counties not maintaining their previous fiscal year's spending levels will be considered to have supplanted county funding with state allocation funds. Counties not complying with their maintenance of effort will be required to return the supplanted portion to the state of Iowa pursuant to Iowa Code section 35A.16(3) as enacted by 2008 Iowa Acts, chapter 1130, and amended by 2009 Iowa Acts, House File 283.

c. Noncompliance. Counties that are not in compliance with the requirements of Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, and 2009 Iowa Acts, House File 283, and Iowa Code section 35B.12 on June 30 of each fiscal year will be required to return all moneys received during that fiscal year to the county commissions of veteran affairs fund pursuant to Iowa Code section 35A.16(3) as enacted by 2008 Iowa Acts, chapter 1130, and amended by 2009 Iowa Acts, House File 283. Counties that are deemed noncompliant due to the termination or resignation of an employee shall not be required to return the state allocation if an employee is hired within two months of the previous employee's separation.

7.1(5) Appeals. Applicants that are dissatisfied with the decision of the Iowa department of veterans affairs may file an appeal with the Iowa commission of veterans affairs. The written appeal must be received within 15 working days of the date of the notice of decision; must be based on a contention that

the process was conducted outside of statutory authority, violated state or federal law, policy or rules, did not provide adequate public notice, was altered without adequate public notice, or involved conflicts of interest by staff; and must include a request that the commission review the decision and the reasons for the appeal. The Iowa commission of veterans affairs shall review the appeal at its next regularly scheduled meeting and shall issue a final decision.

[ARC 7824B, IAB 6/3/09, effective 7/8/09]

801—7.2(35A,35B) County commission of veteran affairs training program. The department shall provide training for county veteran service officers in accordance with Iowa Code section 35A.5(9) as amended by 2008 Iowa Acts, chapter 1130, and Iowa Code section 35A.17 as enacted by 2008 Iowa Acts, chapter 1130.

7.2(1) Training provided by the department shall meet the continuing education requirements as established by NACVSO and shall ensure that each officer and support staff are proficient in the use of electronic mail, computers, and the Internet in order to access information regarding facilities, benefits, and services available to veterans and their families.

7.2(2) A county veteran service officer shall attend and support staff may attend an annual school of instruction provided by the department or a national school of accreditation provided by NACVSO. After attending the annual school of instruction or national school of accreditation, the county veteran service officer must present to the department a certificate of satisfactory completion of national accreditation training from NACVSO. The department shall certify the possession of a document indicating that the county veteran service officer has completed a course of accreditation and satisfactorily passed an examination for NACVSO accreditation. County veteran service officers shall be certified by the department by June 30, 2010, or within one year from the date of appointment.

7.2(3) A county veteran service officer shall maintain certification to remain in office.

a. To maintain certification, a county veteran service officer shall attend an annual school of instruction and meet the continuing education requirements of NACVSO for accreditation. The department shall issue an Iowa certificate of training to the county veteran service officer upon completion of the NACVSO continuing education requirements or upon issuance of a certificate of accreditation by NACVSO.

b. Attendance at training courses sponsored and directed by veterans organizations other than the department or NACVSO may be substituted for the annual school of instruction if the training is sufficient to meet NACVSO accreditation continuing education requirements.

c. County veteran service officers who fail to become accredited by June 30, 2010, or within one year of beginning their employment as provided for in Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, and 2009 Iowa Acts, House File 283, shall be removed from their position by the chair of the county commission of veteran affairs. Knowing violation of this provision constitutes noncompliance as provided in paragraph 7.1(4)“c,” and individuals who knowingly fail to comply may be charged with a serious misdemeanor for nonfelonious misconduct in office as provided by Iowa Code section 721.2(6).

7.2(4) The annual school of instruction and all associated training materials will be provided at the expense of the department.

7.2(5) Travel and lodging expenses incurred while attending the annual school of instruction shall be covered by the respective county.

7.2(6) The executive director shall maintain documentation regarding the school of instruction including, but not limited to, agendas, presentation dates, attendees, certificate of satisfactory completion of accreditation or continuing education training, and the issuance of certificates of training.

7.2(7) Inquiries regarding an annual school of instruction shall be directed to the executive director at the address set out in 801—subrule 1.3(1). The executive director shall answer such inquiries.

7.2(8) Disputes regarding the annual school of instruction, certificates of training, and related matters shall be reviewed by the chairperson of the commission, who will render a decision within 10 days of receipt of all relevant facts and supporting materials. Disputes that are not resolved by the chairperson

shall be referred to the commission. Members of the commission will render a decision within 20 days of receipt of all relevant facts and supporting materials. The decision of the commission shall be final.
[ARC 7824B, IAB 6/3/09, effective 7/8/09]

801—7.3(35A,35B) Report to the general assembly.

7.3(1) Report. The department shall annually within 60 days of the end of the fiscal year report to the general assembly on the following matters:

a. Information related to compliance with the requirements found in Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, and 2009 Iowa Acts, House File 283, and Iowa Code section 35B.12 during the previous fiscal year.

b. The weekly operating schedule of each county commission of veteran affairs office maintained pursuant to Iowa Code section 35B.6 as amended by 2008 Iowa Acts, chapter 1130, and 2009 Iowa Acts, House File 283.

c. The number of hours of veterans' services provided by the executive director or the administrator of each county commission of veteran affairs during the previous fiscal year.

d. Population of each county, including the number of veterans residing in each county.

e. The total amount of compensation, disability benefits, or pensions received by the residents of each county under laws administered by the United States Department of Veterans Affairs.

f. An analysis of the information contained in paragraphs "a" through "e" of this subrule.

7.3(2) County veteran affairs office assistance. Each county commission of veteran affairs shall provide information required in paragraphs 7.3(1) "a" through "c" to enable the department to complete the report. County officers will be provided with a form to return to the department by August 1 of each year.

7.3(3) Report submission. The annual report shall be provided to the president of the Iowa Association of County Veterans Service Officers prior to being presented to the general assembly. Each county veteran affairs office, board of supervisors, and the Iowa commission of veteran affairs shall receive an electronic copy of the submitted report.

[ARC 7824B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code chapters 35A and 35B as amended by 2008 Iowa Acts, chapter 1130, and 2009 Iowa Acts, House File 283.

[Filed ARC 7824B (Notice ARC 7660B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]

CHAPTER 14
VETERANS TRUST FUND

801—14.1(35A) Purpose. These rules establish the requirements for veterans or their spouses or dependents to receive benefits from the veterans trust fund.

801—14.2(35A) Definition. For purposes of this chapter, “veteran” means the same as defined in Iowa Code section 35.1, or a resident of Iowa who served in the armed forces of the United States, completed a minimum aggregate of 90 days of active federal service, other than training, and was discharged under honorable conditions, or a former member of the national guard, reserve, or regular component of the armed forces of the United States who was honorably discharged due to injuries incurred while on active federal service that precluded completion of a minimum aggregate of 90 days of active federal service, other than training.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

801—14.3(35A) Eligibility. Veterans, their spouses, and their dependents applying for benefits available under subrules 14.4(1) through 14.4(9) must meet the following threshold requirements.

14.3(1) Income. For the purposes of this chapter, an applicant’s household income, including VA pension benefits, service-connected disability income, and social security income, shall not exceed 200 percent of the federal poverty guidelines for the number of family members living in the primary residence in effect on the date the application is received by the county director of veterans affairs. Federal poverty guidelines shall be those guidelines established by the Iowa department of human services for the veteran’s family size. The commission shall adjust the guidelines on July 1 of each year to reflect the most recent federal poverty guidelines.

14.3(2) Resources. The department may not pay benefits under this chapter if the available liquid assets of the veteran are in excess of \$15,000. For the purposes of this chapter, “available liquid assets” means cash on hand, cash in a checking or savings account, stocks, bonds, certificates of deposit, treasury bills, money market funds and other liquid investments owned individually or jointly by the applicant and the applicant’s spouse, unless the applicant and spouse are separated or are in the process of obtaining a divorce, but does not include funds deposited in IRAs, Keogh plans or deferred compensation plans, unless the veteran is eligible to withdraw such funds without incurring a penalty. Cash surrender value of life insurance policies, real property, established burial account, or a personal vehicle shall not be included as available liquid assets.

14.3(3) Funding from other sources. Applications shall not be approved if the applicant is eligible to receive aid from other sources to meet the purposes authorized in this chapter.

14.3(4) Additional requirements and limitations. Applicants must meet any additional requirements and are subject to any limitations which may be set out in this chapter or which may be established for a particular benefit.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

801—14.4(35A) Benefits available. Applications may be approved for any of the following purposes. By a majority vote, the commission may suspend some or all of these benefits for payment.

14.4(1) Travel expenses for wounded veterans, and their spouses, directly related to follow-up medical care. Travel expenses under this subrule include the unreimbursed cost of airfare, lodging, and a per diem of \$25 per day for required out-of-state medical travel that exceeds 125 miles from the veteran’s home. Spouses may be reimbursed for in-state lodging and a per diem of \$25 per day when visiting a veteran who is in a hospital for medical care related to a service-connected disability. The distance from the veteran’s home to the hospital must exceed 100 miles. The veteran or the veteran’s spouse shall provide such evidence as the commission may require, which includes but is not limited to evidence the injury or disability is service-connected, the necessity of treatment in a particular facility, and documentation of expenses. The maximum amount for lodging reimbursement shall be \$90. The maximum amount of aid payable in a consecutive 12-month period under this subrule is \$1,000.

14.4(2) *Job training or college tuition assistance for job retraining.*

a. The commission may pay a veteran not more than \$3,000 for retraining or postsecondary education to enable the veteran to obtain gainful employment. The commission may provide aid under this subrule if all of the following apply:

(1) The veteran is enrolled in a training course in a technical college or school, is enrolled in an accredited postsecondary institution, or is engaged in a structured on-the-job training program.

(2) The veteran is unemployed, underemployed, or has received a notice of termination of employment.

(3) The commission determines that the veteran's proposed program, or current program, will provide retraining or initial training that could enable the veteran to find gainful employment. In making its determination, the commission shall consider whether the proposed program, or current program, provides adequate employment skills and is in an occupation for which favorable employment opportunities are anticipated.

(4) The veteran requesting aid has not received full reimbursement or payment from any other retraining or education scholarship programs and the veteran does not have other assets or income available to meet retraining or initial training expenses. Applicants requesting aid under this subrule will only be granted the unpaid portion of their tuition statement, and the payment will be made directly to the institution.

b. The veteran shall provide such evidence as the commission may require to satisfy the requirements of this subrule.

14.4(3) *Unemployment or underemployment assistance during a period of unemployment or underemployment due to prolonged physical or mental illness resulting from military service or disability resulting from military service.* The commission may provide subsistence payments only to a veteran who has suffered a loss of income due to prolonged physical or mental illness resulting from military service or disability resulting from military service. The commission may provide subsistence payments of up to \$500 per month of unemployment or underemployment to a veteran. No payment may be made under this subrule if the veteran has other assets or income available to meet basic subsistence needs. A period of unemployment implies that it is possible for the veteran to be employed in the future. A rating from the VA of 100 percent due to individual unemployability (IU) rated permanent and total indicates that a veteran is unemployable and will not qualify for assistance under this subrule. The veteran shall provide such evidence as the commission may require, which includes but is not limited to evidence that the mental illness or disability is service-connected and evidence that the veteran is unemployed or underemployed for the period of payments. To qualify as underemployed, the applicant must be currently working at an income that is below 150 percent of federal poverty guidelines due to limitations caused by the applicant's service-connected disability or illness. The maximum amount of aid payable in a consecutive 12-month period under this subrule is \$3,000 and a lifetime maximum of \$6,000.

14.4(4) *Expenses related to hearing care, dental care, vision care, or prescription drugs.*

a. The commission may provide health care aid to a veteran, to the veteran's spouse or dependents, or to the unremarried spouse of a deceased veteran for dental care, including dentures; vision care, including eyeglass frames and lenses; hearing care, including hearing aids; and prescription drugs that are not covered by the Veterans Affairs medical center.

b. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$2,500 for dental care, \$500 for vision care, \$1,500 per ear for hearing care, and \$1,500 for prescription drugs.

c. The commission shall not provide health care aid under this subrule unless the aid recipient's health care provider agrees to accept, as full payment for the health care provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. Payment under this subrule will be provided directly to the health care provider. The commission shall not pay health care aid under this subrule if the available liquid assets of the veteran are in excess of \$5,000.

d. Applicants for assistance under this subrule will be required to provide the commission with an unpaid bill for service or an estimated cost of service from the health care provider and documentation of the need for the service. For prescription drugs, the applicant must produce documentation of the need for the prescribed drug and documentation stating whether a generic drug is available or appropriate. The commission payment will not exceed an estimated cost of service by a health care provider.

14.4(5) *Expenses relating to the purchase of durable equipment or services to allow a veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home.*

a. The commission may make reimbursement payments to a veteran or to the unremarried spouse of a deceased veteran for the purchase of durable equipment that allows the veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home or allows them the ability to utilize more of their home.

b. Individuals requesting reimbursement under this subrule will be required to provide verification of the purchase and installation of the equipment and information relating to the need for the equipment. Individuals may also provide a product and installation cost estimate to the commission for approval, with the understanding that the commission will pay no more than the cost estimate to the supplier or installer. Applicants needing durable equipment as a medical necessity should provide information from a physician.

c. Assistance under this subrule cannot duplicate assistance from other entities, and the maximum amount that may be paid may not exceed \$2,500.

d. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of \$5,000.

14.4(6) *Individual counseling or family counseling programs.*

a. The commission may make mental health, substance abuse, and family counseling available to veterans and their families. Individual family members are eligible for counseling.

b. The assistance may include appropriate counseling and treatment programs for veterans and their families in need of services.

c. Any assistance provided under this subrule shall not duplicate other services readily available to veterans and their families. Veterans who are eligible for VA mental health services must initially visit their nearest VA medical facility for initial consultation and continued psychiatric treatment. Payment under this subrule will be made for additional services for the veteran in a location closer to the veteran's home and at a greater frequency than the VA medical center can accommodate.

d. The commission may provide up to \$150 per hour and \$75 per half-hour for outpatient counseling visits to providers who will accept as full payment for the counseling services the amount provided. Counseling and substance abuse services provided in a group setting may be paid up to \$40 per hour. Counseling and substance abuse services may also be provided in an inpatient setting, subject to the maximum amount eligible under 14.4(6) "f."

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period shall not exceed \$5,000. Individuals seeking counseling services are eligible for up to \$2,500, individuals seeking substance abuse treatment and counseling combined are eligible for up to \$3,500, and families seeking counseling services that may also include individual counseling and substance abuse services are eligible for up to \$5,000.

f. The commission may not provide counseling under this subrule unless the aid recipient's counseling service provider agrees to accept, as full payment for the counseling services provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. The commission will make payment directly to the entity providing counseling and substance abuse services. The commission shall not pay for counseling under this subrule if the available liquid assets of the veteran are in excess of \$5,000.

14.4(7) *Expenses relating to ambulance and emergency room services for veterans.*

a. The commission may provide assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for emergency care patients or VA

health care patients that cannot indicate to emergency personnel that they are to be presented to a VA medical center.

b. Funding through this subrule shall be paid directly to the entity providing the emergency service or transportation after the commission is provided with an unpaid bill. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this subrule.

c. The maximum amount that may be paid under this subrule may not exceed \$5,000.

14.4(8) *Emergency expenses related to vehicle repair, housing repair, or temporary housing assistance.*

a. The commission may provide assistance to a veteran or to the unremarried spouse of a deceased veteran for emergency vehicle repair, emergency housing repair, and temporary housing.

b. Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and from work-related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. Assistance may be provided in situations where the applicant does not have sufficient means to pay an insurance deductible. Assistance may be paid directly to the entity performing the maintenance or the insurance company owed the deductible. In certain circumstances, reimbursement may be made to the veteran or to the unremarried spouse of a deceased veteran in order for the vehicle to be released from the entity providing the service. Assistance will not be provided for damage caused during the commission of a crime, for cosmetic needs, for damage resulting in an auto accident when automobile insurance has not been purchased, or for routine maintenance.

c. Assistance for home repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. Applicants with homeowners insurance may request assistance for payment of a deductible. Assistance may be provided for applicants in disaster situations, home accidents, vandalism, or other situations as determined by the commission. In situations where a home is damaged beyond repair, assistance under this subrule is available to assist the applicant in purchasing a new home.

d. Assistance for transitional housing may be provided to applicants who are displaced from their home during a period of repairs related to a disaster, vandalism, home accident, or other reason that makes staying in the home hazardous to the health of the residents. Any refunded security deposits paid for under this subrule shall be returned to the Iowa veterans trust fund.

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$2,500 for vehicle repair, \$3,000 for housing repair, and \$1,000 for transitional housing.

f. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of \$3,000.

14.4(9) *Expenses related to establishing whether a minor child is a dependent of a deceased veteran.*

a. The commission may provide assistance to the family of veterans who are killed while serving on active federal service, for expenses related to paternity or maternity tests or the cost of procuring additional DNA samples from the deceased veteran. This assistance is available to determine whether a child is eligible for United States Department of Veterans Affairs war orphan benefits.

b. Applicants are required to provide the results of the paternity or maternity examinations to the commission upon completion of the tests. Where the deceased veteran is not the parent of the child, the applicant will be required to repay the assistance received as provided in 801—14.6(35A).

c. The maximum amount that may be paid under this subrule is \$2,500.

14.4(10) *Family support group programs or programs for children of members of the military.*

a. The commission may award grants to unit family readiness/support groups, family support offices, and other such organizations providing support and programs to families and children of family members.

b. The grant shall be only for projects or programs which are not funded from any other source. The commission shall determine if the applicant's proposed project or program will provide the intended support. In making its determination, the commission shall consider whether the proposed program will provide anticipated favorable results.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a family readiness/support group is \$500.

14.4(11) Honor guard services.

a. The commission may reimburse veterans organizations for providing military funeral honors as follows:

(1) If a single veterans organization provides basic honors, \$25.

(2) If a single veterans organization provides full honors, \$50.

(3) If two or more veterans organizations participate in providing full honors and one of the organizations provides a firing detail, \$50. The organizations may request that the commission split the reimbursement.

(4) If two or more veterans organizations participate in providing basic honors, \$25. Payment shall be to one veterans organization, as determined by the commission.

b. Notwithstanding paragraph "a," the commission shall not reimburse a veterans organization if federal funding is available to reimburse the veterans organization for providing military funeral honors. The veterans organization shall request reimbursement from federal sources. If a veterans organization receives federal funding for providing military funeral honors at the reimbursement rate of one funeral per day, the department shall reimburse the organization for the provision of military funeral honors at any additional funerals on that day.

c. The maximum amount of aid payable in a calendar year under this subrule to a veterans organization is \$500.

d. Veterans service organizations that are not currently providing honor guard services may apply for a \$500, up-front grant, for the use of creating a new honor guard within their organization. Applicants must present the commission with an estimated cost for purchasing uniforms and firearms for providing military honors and an estimated number of members who will be available to perform honor guard services. Organizations should also provide information regarding how they plan to pay for additional expenses that may occur outside of trust fund assistance. Applicants will be eligible for reimbursements under 14.4(11) "a" to "c" 12 months after the receipt of their original \$500 grant.

14.4(12) Matching funds to veterans service organizations to provide for accredited veteran service officers.

a. The commission may provide matching funds to veterans service organizations for maintaining accredited veteran service officers located at the Des Moines Veterans Affairs Regional Office.

b. Funding for all service organizations combined is available in an amount of up to 20 percent of the interest and earnings on the trust fund balance during the fiscal year or \$150,000, whichever is less.

c. Service organizations requesting funding from the trust fund must provide financial data on the level of organizational funding for the staffing and operation of an office in the Des Moines Veterans Affairs Regional Office. Of the available amount outlined in this subrule, assistance will be split evenly among the service organizations eligible for the trust fund assistance. If the service organization's expenditures are less than their share of the grant, the grant amount will be reduced to the amount of their previous fiscal year's expenditures.

d. Service organizations will be required to maintain the same level of expenditures in the year they receive funding as in the previous year. Funding will be recaptured by the treasurer of the state of Iowa if this funding is used to supplant funding from an individual veterans service organization. Trust fund assistance will not be included in future fiscal year maintenance of effort requirements. A report on the previous fiscal year's expenditures will be required to determine the maintenance of effort for the organization.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

801—14.5(35A) Application procedure. Applications for benefits from the veterans trust fund may be obtained at any county veterans affairs office. The county director of veterans affairs shall date-stamp the application and submit it to the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824.

14.5(1) Application process. A person who wishes to apply shall complete an Application for Veterans Trust Fund form and provide such documentation or other evidence as the commission may require in order to determine the awarding or denial of the benefits available under this chapter.

14.5(2) Date of application. The date of the application shall be the date the signed application and written verification are received by the Iowa department of veterans affairs.

14.5(3) Eligibility determination.

a. The county director of veterans affairs or members of the county commission shall make a recommendation to the Iowa commission of veterans affairs as to whether to approve or deny the application. The Iowa commission of veterans affairs or a subcommittee appointed by the chair shall approve or deny all applications. Applications submitted to the Iowa commission of veterans affairs will be processed at its quarterly meetings as set forth in 801—paragraph 1.2(2)“a” or during a conference call for the purpose of voting on a trust fund expenditure. Applications must be approved by a majority vote of the commission membership or appointed subcommittee. The director of the Iowa department of veterans affairs shall notify an applicant within 15 days of the commission’s decision. An explanation of the reasons for rejection of an application will accompany denials.

b. Applications for honor guard reimbursements under subrule 14.4(11) shall be processed solely by the Iowa department of veterans affairs and do not need commission approval for expenditure of trust fund interest balance funds for this purpose.

14.5(4) Waiting list. After all veterans trust fund moneys have been obligated, the commission shall approve or deny pending applications based on eligibility. Applicants who meet the eligibility requirements and are approved for payment by the commission shall be placed on a waiting list based on the date of approval and then according to the order in which the completed applications and verification were received by the Iowa commission of veterans affairs. In the event that more than one application is received at one time, the applicant shall be entered on the waiting list on the basis of the applicant’s birthday, the oldest applicant being first on the waiting list.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

801—14.6(35A) Recovery of erroneous payments.

14.6(1) Erroneous payments. The commission may recover payments made as a grant under this chapter if any of the following apply:

- a.* The information provided by the applicant is inaccurate.
- b.* The commission incorrectly calculated the grant amount.
- c.* The applicant is not entitled to a grant or is entitled to a lower grant amount as a result of a change in circumstances that affects the applicant’s eligibility to receive the grant.

14.6(2) Amount of recovery. The commission may recover only the portion of the grant to which the applicant would not have been entitled if the correct information had been provided or if the grant had been properly calculated or as a change in circumstances warrants.

14.6(3) Remedies. The commission may request repayment of the amount due under subrule 14.6(2). In lieu of a lump-sum payment, the commission may enter into an agreement under which the applicant may repay the amount due within a 12-month period. If the applicant fails to repay the amount due within 30 days of a request for repayment or fails to comply with the terms of a repayment agreement, the commission may offset future grants that the applicant may be entitled to under this chapter until the amount due has been recovered. The commission may also suspend other benefits available to the applicant until the amount due has been recovered.

14.6(4) Waiver. The commission may temporarily or permanently waive its authority to recover payments under subrule 14.6(1) or suspend benefits under subrule 14.6(3) if the applicant’s household income is totally exempt from Iowa garnishment law.

14.6(5) Appeal. Any commission decision under this chapter is subject to appeal under rule 801—14.7(35A).

801—14.7(35A) Appeal rights.

14.7(1) Subcommittee action. An applicant may appeal the decision of the subcommittee to the full Iowa commission of veterans affairs. The applicant shall appeal the decision of the subcommittee to the commission in writing within 30 days of receiving the written denial and shall provide relevant new information to substantiate the appeal.

14.7(2) Final agency action. The approval or denial of an application by the commission or by the department shall be the final decision of the agency.

14.7(3) Judicial review. Judicial review of the commission's or department's final decisions may be sought in accordance with Iowa Code section 17A.19.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 35A.13 as amended by 2007 Iowa Acts, House File 817, section 7.

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WORKERS' COMPENSATION DIVISION[876]

[Prior to 9/24/86, see Industrial Commissioner[500]. Renamed Division of Industrial Services under the "umbrella" of Employment Services Department by 1986 Iowa Acts, Senate File 2175]
 [Prior to 1/29/97 see Industrial Services Division[343]. Reorganized under "umbrella" of the Department of Workforce Development[871] by 1996 Iowa Acts, chapter 1186]
 [Prior to 7/29/98 see Industrial Services Division[873]]

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876—4.1(85,85A,85B,86,87,17A) Contested cases. Contested case proceedings before the workers' compensation commissioner are:

- 4.1(1) Arbitration (Iowa Code section 86.14).
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- 4.1(19) Matters that would be a contested case if there were a dispute over the existence of material facts.
- 4.1(20) Any other issue determinable upon evidential hearing which is under the jurisdiction of the workers' compensation commissioner.

This rule is intended to implement the provisions of Iowa Code sections 17A.2(2) and 86.8 and the statutory sections noted in each category of the rule.

876—4.2(86) Separate evidentiary hearing or consolidation of proceedings. A person presiding over a contested case proceeding in a workers' compensation matter may conduct a separate evidentiary hearing for determination of any issue in the contested case proceeding which goes to the whole or any material part of the case. An order determining the issue presented shall be issued before a hearing is held on the remaining issues. The issue determined in the separate evidentiary hearing shall be precluded at the hearing of the remaining issues. If the order on the separate issue does not dispose of the whole case, it shall be deemed interlocutory for purposes of appeal.

When any contested case proceeding shall be filed prior to or subsequent to the filing of an arbitration or review-reopening proceeding and is of such a nature that it is an integral part of the arbitration or review-reopening proceeding, it shall be deemed merged with the arbitration or review-reopening proceeding. No appeal to the commissioner of a deputy commissioner's order in such a merged proceeding shall be had separately from the decision in arbitration or review-reopening unless appeal to the commissioner from the arbitration or review-reopening decision would not provide an adequate remedy.

Entitlement to denial or delay benefits provided in Iowa Code section 86.13 shall be pled, and if pled, discovery shall be limited to matters discoverable in the absence of such pleading unless it is bifurcated. The claimant may bifurcate the denial or delay issue by filing and serving a notice of bifurcation at any

time before a case is assigned for hearing, in which case discovery on that issue may proceed only after the final decision of the agency on all other issues.

This rule is intended to implement Iowa Code sections 86.13, 86.18 and 86.24.

876—4.3(85,85A,86,87) Compliance proceedings. If the workers' compensation commissioner shall have reason to believe that there has not been compliance with the workers' compensation law by any person or entity, the commissioner may on the commissioner's own motion give notice to the person or entity and schedule a hearing for the purpose of determining whether or not there has been compliance by the person or entity. The notice shall state the time and place of the hearing and a brief statement of the matters to be considered. The notice of hearing may be given by ordinary mail and may be given to the insurer for the employer in lieu of the employer as permitted by Iowa Code section 87.10 if the insurer has filed a report, pleading or motion that acknowledges that it is the insurer for the claim at issue. Following the hearing, the commissioner may issue a finding regarding compliance. In the event a failure to comply is found, the commissioner may impose sanctions in accordance with Iowa Code sections 86.12, 86.13 or 86.13A or order compliance within a specified time and under specified circumstances. The workers' compensation commissioner may file a certified copy of the order in an appropriate district court and may file a certified copy of the order with the Iowa insurance division [commerce department] with a request for action by the insurance division upon failure to comply with the order.

Nothing in this rule shall prevent the workers' compensation commissioner from conducting an informal conference with any person or entity concerning problems of compliance prior to the initiation of a compliance proceeding.

876—4.4(86) Request for hearing. Unless otherwise ordered a hearing shall not be held in proceedings under 4.1(8) to 4.1(12), unless requested in writing by the petitioner in the original notice or petition or by the respondent within ten days following the time allowed by these rules for appearance.

876—4.5(86) Commencement by commissioner. In addition to an aggrieved party, the commissioner may initiate proceedings under 4.1(9). The proceeding may be held before a deputy commissioner or the commissioner. The workers' compensation commissioner shall be the only person to commence a proceeding under 4.1(13), unless such authority is specifically delegated by the workers' compensation commissioner to a deputy commissioner concerning a specific matter.

876—4.6(85,86,17A) Original notice and petition. A petition or application must be delivered or filed with the original notice unless original notice Form 100, Form 100A or Form 100B of the division of workers' compensation is used.

The original notice Form 100, Form 100A, Form 100B, Form 100C, or a determination of liability reimbursement for benefits paid and recovery of interest form shall provide for the data required in Iowa Code section 17A.12(2) and shall contain factors relevant to the contested case proceedings listed in 876—4.1(85,85A,85B,86,87,17A). Form 100 is to be used for all contested case proceedings except as indicated in this rule. Form 100A is to be used for the contested case proceedings provided for in subrules 4.1(11) and 4.1(12). Form 100B is to be used for the contested case proceeding provided for in subrule 4.1(8). Form 100C is to be used for the contested case proceeding provided for in subrule 4.1(14) and rule 876—4.48(17A,85,86). The application and consent order for payment of benefits under Iowa Code section 85.21 is to be used for contested case proceedings brought under Iowa Code section 85.21. When a commutation is sought, Form No. 9 or Form No. 9A must be filed in addition to any other document. The petition for declaratory order, approval of attorney fees, determination of compliance and other proceedings not covered in the original notice forms must accompany the original notice.

At the same time and in the same manner as service of the original notice and petition, the claimant shall serve a patient's waiver using Form 14-0043 (authorization for release of information regarding claimants seeking workers' compensation benefits), or a substantially equivalent form, which shall not be revoked until conclusion of the contested case. The claimant shall provide the patient's waivers in other

forms and update the patient's waivers as necessary to permit full disclosure of discoverable information whenever requested by a medical practitioner or institution.

For all original notices and petitions filed on or after January 1, 2003, a separate original notice and petition shall be filed for each claim that seeks benefits due to the occurrence of an injury, occupational disease or occupational hearing loss. The original notice and petition shall allege a specific date of occurrence consisting of a day, month and year. Alternate or multiple dates of occurrence may be alleged in the same original notice and petition if the claim or claims arose from the same occurrence or series of occurrences and uncertainty exists concerning the correct date of occurrence or the number of occurrences. An employee may join any number of employers or insurance carriers in the same original notice and petition if the claim is made against them jointly, severally or in the alternative. The remedy for misjoinder must be requested by motion within a reasonable time after the grounds become known, but in no event later than the claimant's case preparation completion date. All remedies will be applied without prejudice to any claim or defense. In addition to the remedies contained in Iowa Rule of Civil Procedure 1.236, the workers' compensation commissioner may order that parts of a claim be severed and proceeded with separately or that separate related claims be joined or consolidated for administrative convenience or for any good cause. If a correction is ordered but not made by a date specified in the order, the original notice and petition may be dismissed without further notice. If the correction is made within the specified time, the correction relates back to the date of the initial filing for purposes of the statute of limitations.

This rule is intended to implement the provisions of Iowa Code sections 85.27, 85.45, 85.48, and 17A.12.

876—4.7(86,17A) Delivery of notice, orders, rulings and decisions. Delivery of the original notice shall be made by the petitioning party as provided in Iowa Code section 17A.12(1) except that a party may deliver the original notice on a nonresident employer as provided in Iowa Code section 85.3. A proposed or final decision, order or ruling may be delivered by the division of workers' compensation to any party by regular mail. On or after July 1, 2009, a proposed or final decision, order or ruling may be delivered by the division of workers' compensation to any party by E-mail.

This rule is intended to implement Iowa Code sections 85.3 and 17A.12.
[ARC 7818B, IAB 6/3/09, effective 7/1/09]

876—4.8(86) Filing of notice.

4.8(1) A contested case is commenced by filing the original notice and petition with the workers' compensation commissioner. No action shall be taken by the workers' compensation commissioner on any contested case against an adverse party unless the adverse party has answered or unless it can be shown by proper proof that the adverse party has been properly served. The original notice and petition if required by 876—4.6(85,86,17A) shall be accompanied by proof that the petitioner has deposited copies of such documents with the U.S. post office for delivery by certified mail, return receipt requested, upon the respondent or has submitted such copies to a proper person for delivery of personal service as in civil actions.

4.8(2) Filing fee.

a. For all original notices and petitions for arbitration or review-reopening relating to weekly benefits filed on account of each injury, gradual or cumulative injury, occupational disease or occupational hearing loss alleged, a filing fee shall be paid at the time of filing. The filing fee for original notices and petitions filed on or after July 1, 1988, but before July 1, 2009, is \$65. The filing fee for petitions filed on or after July 1, 2009, is \$100. No filing fee is due for the filing of other actions where the sole relief sought is one of the following or a combination of any of them: medical and other benefits under Iowa Code section 85.27; burial benefits, Iowa Code section 85.28; determination of dependency, Iowa Code sections 85.42, 85.43, and 85.44; equitable apportionment, Iowa Code section 85.43; second injury fund, Iowa Code sections 85.63 to 85.69; vocational rehabilitation benefits, Iowa Code section 85.70; approval of legal, medical and other fees under Iowa Code section 86.39; commutation, Iowa Code sections 85.45 to 85.48; employee's examination, Iowa Code section

85.39; employee's examination or sanctions, Iowa Code section 85.39; application for alternate care, Iowa Code section 85.27; determination of liability, reimbursement for benefits paid and recovery of interest, Iowa Code section 85.21; interest, Iowa Code section 85.30; penalty, Iowa Code section 86.13; application for approval of third-party settlement, Iowa Code section 85.22; and petitions for declaratory orders or petitions for interventions filed pursuant to 876—Chapter 5. An amendment to a petition that was filed on or after July 1, 1988, that alleges an additional or alternate date of occurrence does not require payment of an additional filing fee if a filing fee was paid when the petition was filed.

b. One filing fee shall be required for as many original notices and petitions as are filed on the same day on account of one employee against a single alleged employer or against entities alleged to be employers in the alternative or alleged to be dual employers. If filing fees have been overpaid, the amount overpaid shall be refunded to the party who made the overpayment.

c. and *d.* Rescinded IAB 11/27/02, effective 1/1/03.

e. If the correct filing fee or fees are not paid at the time of filing of the original notice and petition, the workers' compensation commissioner shall enter an order requiring payment of the correct filing fee or fees. If the required correction is not made by a date specified in the order, the original notice and petition shall automatically be dismissed without prejudice without entry of further order. See rule 876—4.36(86). If correction is made within the specified time, the initial filing shall be sufficient to have tolled the statute of limitations.

If no filing fee is paid at the time of filing of the original notice and petition, the workers' compensation commissioner shall return the original notice and petition to the party filing it. Filing an original notice and petition without paying the fee shall not toll the statute of limitations. Tendering an amount less than required will be considered failure to pay a filing fee.

f. The filing fee may be taxed as a cost to the losing party in the case. If the filing fee would impose an undue hardship or be unjust in the circumstances for the losing party, the filing fee may be taxed as costs to the winning party in the case. If an original notice and petition is erroneously accepted for filing without payment of the correct filing fee or fees, any unpaid fees may be taxed as costs. See rule 876—4.33(86).

g. The filing fee shall be paid at the same time the petition is filed. Checks should be made payable to the "Iowa Division of Workers' Compensation." If the payment of the filing fee is made by an insufficient funds check or a check on which payment is stopped or a check on which payment is otherwise not honored, it will be treated as a failure to pay the correct filing fee. See 4.8(2) "e." One check may be submitted for payment of more than one filing fee if more than one filing fee is due from a petitioner for cases filed on account of an employee. Separate checks must be submitted for each petitioner's case or cases.

h. The workers' compensation commissioner may accept for filing an original notice and petition without prepayment of the filing fee if in the discretion of the workers' compensation commissioner the petitioner is unable to pay the fee at the time of filing. A deferral of payment of the filing fee shall only be granted upon written application by the petitioner. The application shall be filed at the same time the original notice and petition is filed. The application shall be in the form required by the workers' compensation commissioner and shall include an affidavit signed by the petitioner. When payment of the filing fee is deferred, provisions for payment of the filing fee must be included in any settlement submitted to the workers' compensation commissioner for approval or taxed as costs. When the application for deferral of payment of the filing fee is denied, the filing fee shall be paid as ordered. See 4.8(2) "e."

i. Rescinded IAB 1/29/97, effective 3/5/97.

This rule is intended to implement Iowa Code section 17A.12.

[ARC 7818B, IAB 6/3/09, effective 7/1/09]

876—4.9(17A) Appearance and responses, pleading and motions. Responses to pleadings and motions shall be made as follows:

4.9(1) Respondent—appearance. A respondent shall appear by filing an answer or a motion within 20 days after the service of the original notice and petition upon the respondent. The appearance shall include the E-mail address and the fax number of the respondent, if available, if the respondent is not

represented by counsel. The caption of an answer shall disclose the file number of the compliance file in which the first report of injury was filed for the injury that is alleged in the original notice and petition.

4.9(2) Motions. Motions attacking a pleading must be served before responding to a pleading or, if no responsive pleading is required, upon motion made by a party within 20 days after the service of the pleading on such party.

4.9(3) Pleading. Rescinded IAB 11/23/05, effective 1/1/06.

4.9(4) Time after motions attacking pleadings and special appearances. If a motion attacking a pleading is so disposed of as to require further pleading, such further pleading shall be served within ten days after notice of the action of the workers' compensation commissioner or deputy workers' compensation commissioner. If the further pleading requires a response, the response shall be filed within ten days after service of the further pleading.

4.9(5) Amendments to pleadings. A party may amend a pleading as a matter of course at any time before the party's discovery is closed, or if no order is entered closing the party's discovery, at any time before the case is assigned for hearing. Otherwise, a party may amend a pleading only by leave of the workers' compensation commissioner or deputy workers' compensation commissioner or by written consent of the adverse party. Leave to amend, including leave to amend to conform to proof, shall be freely given when justice so requires.

4.9(6) Form, submission and ruling on motions. All motions, including pre-answer motions, motions for summary judgment and applications for adjudication of law points, shall have appended to them a concise memorandum brief and argument. All motions and applications for adjudication of law points except motions for summary judgment shall be deemed submitted without hearing on the record presented on the tenth day following filing. Motions for summary judgment shall be deemed submitted as provided in Iowa Rule of Civil Procedure 1.981. Resistances to motions and applications for adjudication of law points shall have appended to them a concise memorandum brief and argument, and shall be filed on or before the date of submission. Briefs and arguments are waived unless appended to the motion, application or resistance.

An order may be entered consolidating any motion for ruling with hearing of the contested case. Any party desiring a ruling on a motion prior to hearing may concisely set forth the necessity of prior ruling in the motion, application or resistance. If a pre-answer motion alleging lack of jurisdiction is overruled or consolidated with hearing of the contested case, the party shall plead to the merits and proceed to hearing of the contested case without submitting to the jurisdiction of the workers' compensation commissioner. If a motion attacking a pleading is consolidated with hearing of the contested case, the party shall respond to the pleading in the same manner as if the motion had been overruled.

4.9(7) Consolidation. Any party may file a motion to consolidate common questions of fact and law surrounding an injury or a series of injuries. The motion shall be deemed approved if no resistance to the motion is filed with the workers' compensation commissioner within ten days of the filing of the motion. No order granting the motion will be filed by the workers' compensation commissioner. As an alternative, the parties may make an oral motion to consolidate common questions of fact or law at the time of the pretrial hearing. A ruling on the motion will be included with the order issued from the pretrial hearing.

4.9(8) Withdrawal of counsel. Counsel may withdraw if another counsel has appeared or if the client's written consent accompanies the withdrawal.

Under all other circumstances, counsel may withdraw only upon the order of the workers' compensation commissioner after making written application. Counsel shall give the client written notice that the client has the right to object to the withdrawal by delivering written objections and a request for a hearing to the Division of Workers' Compensation, 1000 East Grand Avenue, Des Moines, Iowa 50319, within ten days following the date the notice was mailed or personally delivered to the client. Counsel's application shall be accompanied by proof that a copy of the application and notice was sent by certified mail addressed to the client's last-known address or was delivered to the client personally. If no objections are timely filed, the withdrawal will become effective when approved by the workers' compensation commissioner. If objections are timely filed, a hearing on the application will be held. No withdrawal under this subrule will be effective without the approval of the workers'

compensation commissioner. The filing of an application to withdraw stays all pending matters until a ruling is made on the application.

4.9(9) Requests for default. Requests or motions for default shall be as provided in Iowa Rules of Civil Procedure 1.971 to 1.977 except that entry of default shall be by order of the workers' compensation commissioner or a deputy workers' compensation commissioner.

This rule is intended to implement the provisions of Iowa Code section 17A.12.

876—4.10(86,87) Insurance carrier as a party. Whenever any insurance carrier shall issue a policy with a clause in substance providing that jurisdiction of the employer is jurisdiction of the insurance carrier, the insurance carrier shall be deemed a party in any action against the insured.

This rule is intended to implement Iowa Code section 87.10.

876—4.11(86) Signatures on documents and papers. All documents and papers required by these rules, the Iowa rules of civil procedure as applicable, or a statutory provision shall be signed by the party if unrepresented or the party's attorney if represented. The party's signature in addition to the attorney's signature shall be necessary only when otherwise required by these rules, the Iowa rules of civil procedure as applicable, and any statutory provision.

This rule is intended to implement Iowa Code section 17A.12.

876—4.12(86) Service on parties. Any document or paper not delivered under 876—4.6(85,86,17A) and 876—4.7(86,17A) which is to be filed, or which seeks relief from or action of or against another party, or which makes argument, or which has any significant effect on any contested case, shall be served on each party of record under 876—4.13(86).

This rule is intended to implement Iowa Code sections 17A.12 and 86.18.

876—4.13(86) Method of service. Except as provided in 876—4.6(85,86,17A) and 876—4.7(86,17A), service of all documents and papers to be served according to 876—4.12(86) and 876—4.18(85,86,17A) or otherwise upon a party represented by an attorney shall be made upon the attorney unless service upon the party is ordered by the workers' compensation commissioner. Service upon the attorney or party shall be made by delivery of a copy to or mailing a copy to the last-known address of the attorney or party, or if no address is known, by filing it with the division of workers' compensation. Delivery of a copy within this rule means: Handing it to the attorney or party; leaving it at the office of the attorney or party's office or with the person in charge of the office; or if there is no one in charge of the office, leaving it in a conspicuous place in the office; or if the office is closed or the person to be served has no office, leaving it at the person's dwelling house, or usual place of abode with some person of suitable age and discretion who is residing at the dwelling or abode. Service by mail under this rule is complete upon mailing. No documents or papers referred to in this rule shall be served by the workers' compensation commissioner.

This rule is intended to implement Iowa Code sections 17A.12 and 86.18.

876—4.14(86) Filing of documents and papers. All documents and papers required to be served on a party under rule 876—4.12(86) shall be filed with the workers' compensation commissioner either before service or within a reasonable time thereafter. However, unless otherwise ordered by the workers' compensation commissioner or deputy workers' compensation commissioner, no deposition, notice of deposition, notice of service of interrogatories, interrogatories, request for production of documents, request for admission, notice of medical records and reports required to be served by 876—4.17(86), and answers and responses thereto shall be filed with or accepted for filing by the workers' compensation commissioner unless its use becomes otherwise necessary in the action, in which case it shall be attached to the motion or response to motion requiring its use, or unless offered as evidence at hearing of the contested case.

This rule is intended to implement Iowa Code section 86.18.

876—4.15(86) Proof of service. Proof of service of all documents and papers to be served on another party under 876—4.12(86) shall be filed with the division of workers' compensation promptly, and in

any event, before action is to be taken thereon by the workers' compensation commissioner or any party unless a responsive pleading has been filed. The proof shall show the date and manner of service and may be by written acknowledgment of service, by certification of a member of the bar of this state, by affidavit of the person who served the papers, or by any other proof satisfactory to the workers' compensation commissioner.

This rule is intended to implement Iowa Code section 86.18.

876—4.16(86) Request for copy. No person requesting a mailed file-stamped copy of a filing made in a contested case shall receive such a copy unless the request shall be accompanied by a self-addressed envelope with sufficient postage. In addition, no party requesting a file-stamped copy of a filing made by the party in a contested case shall receive such a copy unless the request shall be accompanied by sufficient copies to allow the requesting party to receive a copy.

This rule is intended to implement Iowa Code section 86.18.

876—4.17(17A,85,86) Service of records and reports. Each party to a contested case shall serve all records received pursuant to a patient's waiver (Form 14-0043—authorization for release of information regarding claimants seeking workers' compensation benefits) and medical records and reports concerning the injured worker in the possession of the party upon each opposing party not later than 20 days following filing of an answer or, if not then in possession of a party, within 10 days of receipt. Medical records and reports are records of medical practitioners and institutions concerning the injured worker. Medical practitioners and institutions are medical doctors, osteopaths, chiropractors, dentists, nurses, podiatrists, psychiatrists, psychologists, counselors, hospitals, clinics, persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation, all other practitioners of the healing arts or sciences, and all other institutions in which the healing arts or sciences are practiced. Each party shall serve a notice accompanying the records and reports identifying the records and reports served by the name of the practitioner or institution or other source and date of the records and reports and, if served later than 20 days following filing of the answer, stating the date when the records and reports were received by the party serving them. Pursuant to 876—4.14(86), the notice and records and reports shall not be filed with the workers' compensation commissioner. A party failing to comply with the provisions of this rule shall, if the failure is prejudicial to an opposing party, be subject to the provisions of 876—4.36(86). This rule does not require a party to serve any record or report that was previously served by another party in a contested case proceeding.

For hearings on or after July 1, 2004, compliance with this rule does not permit a record or report to be received into evidence if the record or report was not served prior to an applicable deadline established by rule or order for completing discovery or service of exhibits.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.18(17A,85,86) Medical evidence and discovery. Discovery in workers' compensation proceedings is governed by the rules of civil procedure pursuant to 876—4.35(86). Any relevant medical record or report served upon a party in compliance with these rules prior to any deadline established by order or rule for service of the records and reports shall be admissible as evidence at hearing of the contested case unless otherwise provided by rule. Any party against which a medical record or report may be used shall have the right, at the party's own initial expense, to cross-examine by deposition the medical practitioner producing the record or report and the deposition shall be admissible as evidence in the contested case.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.19(86) Prehearing procedure.

4.19(1) Prehearing procedure in contested cases shall be administered in accordance with these rules and the orders issued by the workers' compensation commissioner or a deputy workers' compensation commissioner.

4.19(2) Counsel of record and pro se litigants have a duty to exercise reasonable diligence to bring the contested case to hearing at the earliest reasonable opportunity.

4.19(3) For contested cases that were filed on or after July 1, 2004, the following time limits govern prehearing procedure, completion of discovery and case management in contested cases, except proceedings under rules 876—4.46(17A,85,86) and 876—4.48(17A,85,86) and except when otherwise ordered by the workers' compensation commissioner or a deputy workers' compensation commissioner.

a. Within 120 days, but not less than 60 days, following filing of a petition, the counsel of record for all parties and all pro se litigants shall jointly contact the hearing administrator by telephone at (515)281-6621 between the hours of 8:30 a.m. and 11 a.m. central time, Monday through Friday, excluding holidays, or by E-mail at dwc.hearing@iwd.state.ia.us to schedule a hearing date, place and time. Claimant has primary responsibility for initiating the contact. The parties shall identify the case by file number and the names of the parties and request that the hearing be set at a specific date, place and time that is shown to be available on the hearing scheduler published on the division's Web site. Primary and backup times must be requested for hearings in venues other than Des Moines. When the contact is made by E-mail, a copy of the request shall be sent to each opposing party, and the hearing administrator will reply indicating whether or not the case is assigned at the time requested. If a request is denied, the parties shall continue to contact the hearing administrator by telephone or E-mail until the case is scheduled or a prehearing conference is ordered. A joint scheduling contact may be initiated by any party at any other time agreeable to the parties. If more than 120 days have elapsed since the petition was filed, any party may move to schedule the hearing at a particular date, time and place that is available and the hearing administrator may assign the case for hearing at that date, time and place. The hearing date shall be within 12 months following the date the petition was filed or as soon thereafter as reasonably practicable as determined by the hearing administrator. If the parties fail to schedule the hearing with the hearing administrator, the case will be scheduled at the discretion of the hearing administrator without prior notice to the parties.

b. A party who intends to introduce evidence from an expert witness, including a rebuttal expert witness, shall certify to all other parties the expert's name, subject matter of expertise, qualifications, and a summary of the expert's opinions within the following time period: (1) claimant—120 days before hearing; (2) employer/second injury fund of Iowa—90 days before hearing; (3) rebuttal—60 days before hearing. Certification is not required to introduce evidence from an examining physician pursuant to Iowa Code section 85.39, a treating physician, or a vocational consultant if the expert witness is known by all parties to have personally provided services to the claimant and the witness's reports are served on opposing parties prior to the date when certification is required. The parties may alter these times by written agreement.

c. Discovery responses must be supplemented as required in Iowa Rules of Civil Procedure 1.503(4) and 1.508(3). Discovery responses shall be supplemented within 20 days after a party requests supplementation. All discovery responses, depositions, and reports from independent medical examinations shall be completed and served on opposing counsel and pro se litigants at least 30 days before hearing. The parties may alter these times by written agreement.

d. At least 30 days before hearing, counsel of record and pro se litigants shall serve a witness and exhibit list on all opposing counsel and pro se litigants and exchange all intended exhibits that were not previously required to be served. The witness list shall name all persons, except the claimant, who will be called to testify at the hearing or who will be deposed prior to the hearing in lieu of testifying at the hearing. The exhibit list must specifically identify each exhibit in a way that permits the opposing party to recognize the exhibit. The description for a document should include the document's date, number of pages and author or source. Exhibits that were specifically identified when served pursuant to rule 876—4.17(17A,85,86) or in a discovery response may be collectively identified by describing the service such as "exhibits described in the notices served pursuant to rule 876—4.17(17A,85,86) on May 7, June 11 and July 9, 2004." Blanket references such as "all medical records," "personnel file" or "records produced during discovery" do not specifically identify an exhibit. A party may serve a copy of the actual intended exhibits in lieu of an exhibit list. Evidentiary depositions pursuant to Iowa Code section 86.18(2) may be taken at any time before the hearing in lieu of the witness testifying at the hearing.

e. If evidence is offered at hearing that was not disclosed in the time and manner required by these rules, as altered by order of the workers' compensation commissioner or a deputy workers' compensation commissioner or by a written agreement by the parties, the evidence will be excluded if the objecting party shows that receipt of the evidence would be unfairly prejudicial. Sanctions may be imposed pursuant to 876—4.36(86) in addition to or in lieu of exclusion if exclusion is not an effective remedy for the prejudice.

f. Counsel and pro se litigants shall prepare a hearing report that defines the claims, defenses, and issues that are to be submitted to the deputy commissioner who presides at the hearing. The hearing report shall be signed by all counsel of record and pro se litigants and submitted to the deputy when the hearing commences.

876—4.20(86) Prehearing conference. A deputy commissioner or the workers' compensation commissioner may order parties in the case to either appear before the commissioner or a deputy commissioner for a conference, or communicate with the commissioner or the commissioner's designee and with each other in any manner as may be prescribed to consider, so far as applicable to the particular case:

1. The necessity or desirability of amending pleadings by formal amendment or prehearing order;
2. Agreeing to admissions of facts, documents or records not really controverted, to avoid unnecessary proof;
3. Limiting the number of witnesses;
4. Settling any facts of which the commissioner or deputy commissioner is to be asked to take official notice;
5. Stating and simplifying the factual and legal issues to be determined;
6. Specifying the items and amounts of compensation claimed;
7. Specifying all proposed exhibits and proof thereof;
8. Consolidation, separation for hearing, and determination of points of law;
9. Specifying all witnesses expected to testify;
10. Possibility of settlement;
11. Filing of advance briefs, if any;
12. Setting or altering dates for completion of discovery or completion of medical evidence by each party;
13. Any other matter which may facilitate, expedite, or simplify any contested case.

This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.21(86) Prehearing conference record. At the request of any attorney in the case, or at the discretion of a deputy commissioner or the workers' compensation commissioner, the entire prehearing conference or any designated part thereof shall be recorded and the cost of the reporter shall be assessed to the requesting party, or if directed by the commissioner or deputy commissioner, assessed as costs.

This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.22(86) Orders. The deputy commissioner or workers' compensation commissioner may enter an order reciting any action taken at the conference or pursuant to any other procedures prescribed which will control the subsequent course of action relative to matters which it includes, unless modified to prevent manifest injustice.

This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.23(86) Assignment for hearing. Contested cases shall be set for hearing within the discretion of the workers' compensation commissioner as soon as practicable after the parties have had adequate opportunity to prepare for hearing. A party may request in writing that no hearing in a contested case be held until such time as specified matters have been accomplished or specified events have occurred. Continuances of hearings in contested cases shall be granted only by the workers' compensation commissioner or the commissioner's designee. Continuances are governed by Iowa Rules of Civil

Procedure 1.910-1.912. Requests for continuance shall also state in detail the reasons for the request and whether the opposing party accedes to the request.

Defendants shall promptly notify the workers' compensation commissioner of settlements.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.24(17A,86) Rehearing. Any party may file an application for rehearing of a proposed decision in any contested case by a deputy commissioner or a decision in any contested case by the workers' compensation commissioner within 20 days after the issuance of the decision. A copy of such application shall be timely mailed by the applicant to all parties of record not joining therein. An application for rehearing shall be deemed denied unless the deputy commissioner or workers' compensation commissioner rendering the decision grants the application within 20 days after its filing. For purposes of this rule, motions or requests for reconsideration or new trial or retrial or any reexamination of any decision, ruling, or order shall be treated the same as an application for rehearing.

876—4.25(17A,86) Appeal when rehearing requested. An appeal to or review on motion of the workers' compensation commissioner must be filed within 20 days after the application for rehearing of a proposed decision by a deputy workers' compensation commissioner under 876—4.24(17A,86) has been denied or deemed denied or a decision on rehearing has been issued. If a notice of appeal is filed by one party and an application for rehearing is filed by a different party, the deputy retains jurisdiction to act on the application for rehearing, and the notice of appeal is stayed and deemed to have been filed on the day after the application for rehearing is denied or deemed denied or the decision on rehearing is issued.

This rule is intended to implement Iowa Code sections 17A.15, 17A.16 and 86.24.

876—4.26 Rescinded, effective July 1, 1977.

876—4.27(17A,86) Appeal. Except as provided in 876—4.2(86) and 876—4.25(17A,86), an appeal to the commissioner from a decision, order or ruling of a deputy commissioner in contested case proceedings shall be commenced within 20 days of the filing of the decision, order or ruling by filing a notice of appeal with the workers' compensation commissioner. If two or more contested cases were consolidated for hearing, a notice of appeal in one of the cases is an appeal of all the cases. The date the notice of appeal is filed shall be the date the notice of appeal is received by the agency. *Miller v. Civil Constructors*, 373 N.W.2d 115 (Iowa 1985). The notice shall be served on the opposing parties as provided in 876—4.13(86). An appeal shall be heard in Polk County or in any location designated by the workers' compensation commissioner.

An interlocutory decision, order or ruling can be appealed only as hereinafter provided. A decision, order or ruling is interlocutory if, when issued, it does not dispose of all issues in the contested case that are ripe for adjudication. If the sole issue remaining for determination is claimant's entitlement to additional compensation for unreasonable denial or delay of payment pursuant to Iowa Code section 86.13, the decision is not interlocutory. An adjudication that awards ongoing payments of weekly compensation under Iowa Code section 85.33 or 85.34(1) is not interlocutory. The workers' compensation commissioner may, upon application from any party or on the commissioner's own motion, and upon such terms as the commissioner orders, grant an appeal from an interlocutory decision, order or ruling if the commissioner finds that the ruling affects substantial rights, that the ruling will materially affect the final decision and that determination of the correctness of the ruling will better serve the interests of justice.

A cross-appeal may be taken under this rule or 876—4.25(17A,86) in the same manner as an appeal within the 20 days for the taking of an appeal or within 10 days after filing of the appeal, whichever is later.

This rule is intended to implement Iowa Code sections 17A.15 and 86.24.

876—4.28(17A,86) Briefing requirements on appeal. The commissioner shall decide an appeal upon the record submitted to the deputy workers' compensation commissioner unless the commissioner

is satisfied that there exists additional material evidence, newly discovered, which could not with reasonable diligence be discovered and produced at the hearing. A party must file a request for taking additional evidence within 20 days after the notice of appeal was filed. Any briefs required or allowed by this rule shall be filed promptly following service.

4.28(1) *Time for serving briefs.* Appellant shall serve its brief within 50 days after the date on which notice of appeal was filed, or within 20 days after filing of the hearing transcript, whichever date is later. Appellee shall serve its brief within 20 days after service of the brief of appellant. If appellant serves a reply brief, it shall be done within 10 days after service of appellee's brief.

4.28(2) *Cross-appeals.* In the event of a cross-appeal, appellee (cross-appellant) shall serve its brief within 20 days after service of the brief of appellant. Appellant (cross-appellee) shall serve its responsive reply brief within 20 days after service of the brief of appellee. Appellee (cross-appellant) may serve a reply brief within 10 days after service of appellant's reply brief. When both parties appeal, the first to serve notice of appeal shall be appellant unless both serve their notice on the same date, in which case the claimant shall be appellant.

4.28(3) *Multiple adverse parties.* In cases involving multiple appeals involving multiple claimants, employers, insurance carriers or the second injury fund, the workers' compensation commissioner shall enter an order establishing a briefing schedule.

4.28(4) *Form of briefs.* Respective briefs and exceptions on appeal shall include the following:

- a. Statement of the case.
- b. Statement of the issues on appeal.
- c. An argument corresponding to the separately stated issues and contentions of appellant with respect to the issues presented and reasons for them, with specific reference to the page or pages of the transcript which are material to the issues on appeal.
- d. A short conclusion stating the precise relief sought.

The appellee may submit a brief on appeal replying to the issues presented by the appellant, unless a cross-appeal is made in which case the brief of appellee shall contain the issues and argument involved in the cross-appeal as well as the response to the brief of appellant.

4.28(5) *Length of briefs.* See rule 876—4.45(17A,86).

4.28(6) *Extensions.* One extension of up to 30 days will be granted if a motion to extend the time is served on or before the date service of the brief is required by this rule. A subsequent extension requires a motion showing good cause. The commissioner may grant a party the right to serve and file a brief after the time to do so has expired if the appeal or cross-appeal has not been dismissed or decided, the party moves for relief within 60 days from the date service of the brief was due, and the motion shows that the failure to timely serve the brief was due to a good cause that could not have been avoided through the exercise of reasonable diligence.

4.28(7) *Issues considered on appeal.* The appeal will consider the issues presented for review by the appellant and cross-appellant in their briefs and any issues necessarily incident to or dependent upon the issues that are expressly raised, except as provided in 876—4.29(86,17A). An issue will not be considered on appeal if the issue could have been, but was not, presented to the deputy. An issue raised on appeal is decided de novo and the scope of the issue is viewed broadly. If the ruling from which the appeal was taken made a choice between alternative findings of fact, conclusions of law, theories of recovery or defenses and the alternative selected in the ruling is challenged as an issue on appeal, de novo review includes reconsideration of all alternatives that were available to the deputy.

4.28(8) *Sanctions.* If an appellant's brief or cross-appellant's brief is not served and filed within the time required by this rule, including any extension, the party defending against the appeal or cross-appeal may move for dismissal. If an appellant's brief or cross-appellant's brief is not served within 30 days after the time required by these rules, including any extension, the workers' compensation commissioner will notify the party in default that upon 15 days from service of the notification the appeal or cross-appeal will be dismissed for want of prosecution unless the default is remedied within that period. If the default is not remedied, the appeal or cross-appeal will be dismissed. If an appellee's brief or cross-appellee's brief is not served and filed, the appeal will be decided without reference to that brief.

This rule is intended to implement Iowa Code section 86.24.

876—4.29(86,17A) Review upon motion. Except as provided in 876—4.25(17A,86) the commissioner may review the decision, order or ruling of a deputy commissioner in any contested case upon the commissioner's own motion. Except as provided in 876—4.25(17A,86), the motion to review a decision, order or ruling in all contested cases must be filed within 20 days of the filing of the decision, order or ruling. The commissioner shall specify in a notice mailed to the parties by certified mail, return receipt requested, on the date of filing of the motion the issues to be reviewed and the additional evidence, if any, to be obtained by the parties. The hearing under this rule shall be heard in Polk County or in any locality designated by the workers' compensation commissioner.

This rule is intended to implement Iowa Code sections 17A.15 and 86.24.

876—4.30(86,17A) Transcript on appeal or review. When an appeal to or review on motion of the commissioner is taken pursuant to 876—4.27(17A,86) or 876—4.29(86,17A), a transcript of the proceedings before the workers' compensation commissioner shall be filed with the workers' compensation commissioner within 30 days after the notice of the appeal is filed with the workers' compensation commissioner. The appealing party shall bear the initial cost of transcription on appeal and shall pay the certified shorthand reporter or service for the transcript. In the event there is a cross-appeal, the appellant and cross-appellant shall share the cost of the transcript. In the event the cost of the transcript has been initially borne by a nonappealing party prior to appeal, the nonappealing party is entitled to reimbursement within 30 days after serving on the appealing party proof of the cost of the transcript. If not so reimbursed, the appeal may be dismissed.

This rule is intended to implement Iowa Code sections 17A.12, 17A.15, 86.19, 86.24 and 86.40.

876—4.31(86) Completion of contested case record. No evidence shall be taken after the hearing.

This rule is intended to implement Iowa Code section 86.18.

876—4.32(86,17A) Recording of proceedings. The workers' compensation commissioner may arrange for the attendance of a certified shorthand reporter or mechanical means to record proceedings in contested cases. The workers' compensation commissioner may require the defendant employer or on appeal to the commissioner, the appellant, to arrange for the attendance of a certified shorthand reporter or adequate mechanical means of recording the proceedings. The charges for attendance shall be paid initially to the certified shorthand reporter or service by the employer or on an appeal to the commissioner, the appellant. The charges shall be taxed as costs. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost.

This rule is intended to implement Iowa Code section 86.19.

876—4.33(86) Costs. Costs taxed by the workers' compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors' and practitioners' deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors' or practitioners' reports, (7) filing fees when appropriate, (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors' or practitioners' reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers' compensation commissioner before it is taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of

the deputy commissioner or workers' compensation commissioner hearing the case unless otherwise required by the rules of civil procedure governing discovery.

This rule is intended to implement Iowa Code section 86.40.

876—4.34(86) Dismissal for lack of prosecution. It is the declared policy that in the exercise of reasonable diligence, all contested cases before the workers' compensation commissioner, except under unusual circumstances, shall be brought to issue and heard at the earliest possible time. To accomplish such purpose the workers' compensation commissioner may take the following action:

4.34(1) Any contested case, where the original notice and petition is on file in excess of two years, may be subject to dismissal after the notice in 4.34(2) is sent to all parties and after the time as provided for in the notice.

4.34(2) After the circumstances provided in 4.34(1) occur, all parties to the action, or their attorneys, shall be sent notice from the division of workers' compensation by certified mail containing the following:

- a. The names of the parties;
- b. The date or dates of injury involved in the contested case or appeal proceeding;
- c. Counsel appearing;
- d. Date of filing of the petition or appeal;
- e. That the contested case proceeding will be dismissed without prejudice on the thirtieth day following the date of the notice unless good cause is shown why the contested case proceeding should not be dismissed.

4.34(3) The action or actions dismissed may at the discretion of the workers' compensation commissioner and shall upon a showing that such dismissal was the result of oversight, mistake or other reasonable cause, be reinstated. Applications for such reinstatement, setting forth the grounds, shall be filed within three months from the date of dismissal.

This rule is intended to implement Iowa Code sections 86.8, 17A.3(1)“b” and 86.18.

876—4.35(86) Rules of civil procedure. The rules of civil procedure shall govern the contested case proceedings before the workers' compensation commissioner unless the provisions are in conflict with these rules and Iowa Code chapters 85, 85A, 85B, 86, 87 and 17A, or obviously inapplicable to the workers' compensation commissioner. In those circumstances, these rules or the appropriate Iowa Code section shall govern. Where appropriate, reference to the word “court” shall be deemed reference to the “workers' compensation commissioner” and reference to the word “trial” shall be deemed reference to “contested case hearing.”

This rule is intended to implement Iowa Code sections 17A.1, 17A.12, 17A.13, 17A.14, and 86.8.

876—4.36(86) Compliance with order or rules. If any party to a contested case or an attorney representing such party shall fail to comply with these rules or any order of a deputy commissioner or the workers' compensation commissioner, the deputy commissioner or workers' compensation commissioner may impose sanctions which may include dismissing the action without prejudice, excluding or limiting evidence, assessing costs or expenses, and closing the record in whole or in part to further activity by the party.

This rule is intended to implement Iowa Code section 86.8.

876—4.37(86,17A) Waiver of contested case provisions. The parties who wish to waive the contested case provisions of chapter 17A shall file a written stipulation of such waiver with the workers' compensation commissioner before such waiver shall be recognized. The waiver shall specify the provisions waived such as a consent to delivery, waiver of original notice, or waiver of hearing.

This rule is intended to implement Iowa Code section 17A.10.

876—4.38(17A) Recusal.

4.38(1) The workers' compensation commissioner, a chief deputy workers' compensation commissioner or a deputy workers' compensation commissioner 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;
- g.* Has even the appearance of impropriety; or
- h.* Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

4.38(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 Iowa Code section 17A.17 and rule 876—4.38(17A).

4.38(3) In a situation where the workers' compensation commissioner, chief deputy workers' compensation commissioner or deputy workers' compensation commissioner knows of information which might reasonably be deemed to be a basis for recusal 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.

4.38(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 4.38(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(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 recusal but must establish the grounds by the introduction of evidence into the record.

If the workers' compensation commissioner, chief deputy workers' compensation commissioner or deputy workers' compensation commissioner determines that recusal is appropriate, that person shall withdraw. If that person determines that withdrawal is not required, that person shall enter an order to that effect.

This rule is intended to implement Iowa Code section 17A.17.

876—4.39(17A,86) Filing by facsimile transmission (fax). All documents filed with the agency pursuant to this chapter and Iowa Code section 86.24 except an original notice and petition requesting a contested case proceeding (see Iowa Code section 17A.12(9)) may be filed by facsimile transmission

(fax). A copy shall be filed for each case involved. 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 may be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax is the date the document is received by the agency. The agency will not provide a mailed file-stamped copy of documents filed by fax. The agency fax number is (515)281-6501.

876—4.40(73GA,ch1261) Dispute resolution. The workers' compensation commissioner or the workers' compensation commissioner's designee (hereinafter collectively referred to as the workers' compensation commissioner) shall have all power reasonable and necessary to resolve contested cases filed under Chapter 4 of these rules. This power includes, but is not limited to, the following: the power to resolve matters pursuant to initiation of mandatory dispute resolution proceedings by the workers' compensation commissioner; the power to resolve matters pursuant to a request by the parties; the power to impose sanctions; and the power to require conduct by the parties. However, no issue in a contested case may be finally resolved under this rule without consent of the parties.

An employee of the division of workers' compensation who has been involved in dispute resolution shall not be a witness in any contested case proceeding under this chapter.

4.40(1) Mandatory proceedings. The workers' compensation commissioner may require that the parties participate in dispute resolution in the following situation:

- a. The oldest one-fourth of contested cases which are not scheduled for hearing.
- b. All cases where discovery deadlines have been set pursuant to a prehearing order and the deadlines have passed.
- c. All cases where the principal dispute is medical benefits.
- d. All cases where the only dispute is the extent of disability.
- e. All cases involving liability disputes of alleged workers' compensation insurance carriers and alleged employers pursuant to Iowa Code section 85.21.
- f. Equitable apportionment of compensation payments pursuant to Iowa Code section 85.43.
- g. All cases where the workers' compensation commissioner determines that dispute resolution would be in the best interest of the parties.

4.40(2) Voluntary proceedings. The parties may voluntarily agree to submit to dispute resolution.

4.40(3) The parties must comply with the good faith requirements of rule 876—10.1(17A,85,86) before requesting a voluntary proceeding pursuant to subrule 4.40(2).

4.40(4) See 876—subrule 10.1(5) regarding informal dispute resolution.

4.40(5) Rescinded IAB 9/14/94, effective 10/19/94.

This rule is intended to implement Iowa Code sections 17A.10, 86.8 and 86.13 and 1990 Iowa Acts, chapter 1261, section 3.

876—4.41(17A,86) Evidence. Rescinded IAB 1/29/97, effective 3/5/97.

876—4.42(17A,86) Binding arbitration. Rescinded IAB 1/29/97, effective 3/5/97.

876—4.43(17A,85,86) Summary trial. Rescinded IAB 9/14/94, effective 10/19/94.

876—4.44(17A,85,85A,85B,86,87) Expedited proceeding—criteria. Rescinded IAB 1/29/97, effective 3/5/97.

876—4.45(17A,86) Length of briefs. Except by permission of the presiding deputy workers' compensation commissioner or by permission of the workers' compensation commissioner when an appeal pursuant to rule 876—4.27(17A,86) has been filed, principal briefs shall not exceed 50 Arabic-numbered pages. Reply briefs shall not exceed 25 Arabic-numbered pages. Permission may be granted ex parte. In the event of a cross-appeal, appellant's (cross-appellee's) responsive reply brief shall be considered a principal brief. The type used shall not be smaller than pica type and each line shall contain an average of no more than 60 characters. If a brief is submitted in excess of the length allowed in this rule, the portion exceeding the allowable length will not be considered. This rule does

not prohibit a presiding deputy workers' compensation commissioner or the workers' compensation commissioner from limiting the length of a brief. An exception to this rule is the length of briefs (three pages) in an application for alternate care. See subrule 4.48(11).

This rule is intended to implement Iowa Code sections 17A.12, 17A.15, 86.8, 86.18 and 86.24.

876—4.46(17A,85,86) Contested case proceedings—health service disputes.

4.46(1) See rule 876—10.3(17A,85,86) for informal resolution procedures and definitions. The following definition also applies to this rule:

"Petitioning party" means the person who requests or initiates a contested case proceeding.

4.46(2) If utilization of the procedures given in rule 876—10.3(17A,85,86) does not resolve the dispute and the parties have complied with the good faith requirements of rule 876—10.1(17A,85,86), a contested case may be initiated. The procedures given in rule 876—10.3 (17A,85,86) must be used prior to initiation of a contested case. The provider or the responsible party that is unwilling to accept the determination of the person making a determination after reviewing the dispute as provided in rule 876—10.3(17A,85,86) shall initiate the contested case proceeding. The proceeding shall be initiated as provided in this chapter and Iowa Code chapter 17A and shall follow the provisions of this rule. The proceeding must be initiated within 30 days of the date of the determination made pursuant to rule 876—10.3(17A,85,86). If a contested case proceeding is not initiated or is not initiated within the time provided in this rule, the allowed amount of the charge by the provider shall be the amount determined pursuant to rule 876—10.3(17A,85,86).

4.46(3) The evidence submitted in the contested case proceeding shall be limited to the evidence submitted pursuant to rule 876—10.3(17A,85,86) and a copy of the determination made pursuant to rule 876—10.3(17A,85,86). This evidence shall be filed by the party requesting the contested case proceeding at the time the contested case proceeding is initiated. However, the workers' compensation commissioner may request that additional evidence be submitted or may grant submission of additional evidence if the commissioner is satisfied that there exists additional material evidence, newly discovered, which could not with reasonable diligence be discovered and produced pursuant to rule 876—10.3(17A,85,86). The issues of the contested case proceeding shall be limited to the dispute considered in rule 876—10.3(17A,85,86).

4.46(4) The petitioning party has the burden of proof.

4.46(5) If the petitioning party wishes to file a brief, it must be filed with the request for contested case proceeding.

4.46(6) The opposing party must file a response within 30 days of the date of service of the request for contested case proceeding.

4.46(7) If the opposing party wishes to file a brief, it must be filed with the response.

4.46(8) Sixty days after the request for contested case is filed with the workers' compensation commissioner, the workers' compensation commissioner will review the matter. The notice of the review to the parties shall be the provisions of this rule and no other notice will be given.

4.46(9) The workers' compensation commissioner shall review the matter and make a decision as soon as practicable after the review. The decision shall be as provided in this chapter and Iowa Code chapter 17A.

This rule is intended to implement Iowa Code sections 17A.10, 17A.12, 17A.14, 85.27, 86.8 and 86.39.

876—4.47(17A,85,86) Second injury fund benefits contested cases. Rescinded IAB 6/22/94, effective 7/1/94.

876—4.48(17A,85,86) Application for alternate care.

4.48(1) *Effective date.* This rule is effective for applications for alternate care received on or after July 1, 1992.

4.48(2) *Purpose.* The purpose of this rule is to establish the procedures for issuing decisions on applications for alternate care within the time provided in Iowa Code section 85.27.

4.48(3) Definitions. The following definitions apply to this rule:

"Application for alternate care," hereinafter referred to as "application," shall mean a contested case proceeding filed with the workers' compensation commissioner which requests alternate care pursuant to Iowa Code section 85.27.

"Employer" means the person who is liable for payment of medical services provided pursuant to the Iowa workers' compensation laws and includes an employer, an employer who has been relieved from insurance pursuant to Iowa Code section 87.11, and an insurance carrier which provides an employer workers' compensation insurance.

"Proper application" means an application for alternate care that complies with the requirements of this rule.

4.48(4) Dissatisfaction—basis. Prior to filing the application the employee must communicate the basis of dissatisfaction of the care to the employer.

4.48(5) Application. The application shall: be filed on the form provided by the workers' compensation commissioner; concern only the issue of alternate care; state the reasons for the employee's dissatisfaction with the care chosen by the employer; be served on the employer; contain proof of service on the employer; and specify whether a telephone or in-person hearing is requested.

4.48(6) Fee. No filing fee is due. See 4.8(2) "a."

4.48(7) Employer liability. Application cannot be filed under this rule if the liability of the employer is an issue. If an application is filed where the liability of the employer is an issue, the application will be dismissed without prejudice. (Petitions for alternate care where liability of the employer is an issue should be filed pursuant to rule 876—4.1(85,85A,85B,86,87,17A).)

4.48(8) Notice of hearing. The workers' compensation commissioner will notify the parties by ordinary mail or by facsimile transmission (fax) of the time, place and nature of hearing. No notice will be made until a proper application is received by the workers' compensation commissioner. The notice will specify whether the hearing will be by telephone or in person.

4.48(9) Discovery and evidence. All discovery must be completed prior to the contested case hearing. See subrule 4.48(10) on motions on discovery matters. Any written evidence to be used by the employer or the employee must be exchanged prior to the hearing. All written evidence must be filed with the agency before the date of the hearing. Written evidence shall be limited to ten pages per party.

4.48(10) Motions. All motions except as provided in this subrule will be considered at the hearing. A timely motion to change the type of hearing (telephone or in-person) may be considered prior to the hearing. The workers' compensation commissioner will make no rulings on discovery matters or motions.

4.48(11) Briefs. Hearing briefs, if any, must be filed with the agency before the date of the hearing and shall be limited to three pages.

4.48(12) Hearing. The hearing will be held either by telephone or in person in Des Moines, Iowa. The employer shall have the right to request an in-person hearing if the employee has requested a telephone hearing in the application. The employer shall on the record respond to the allegations contained in the application. The hearing will be electronically recorded. If there is an appeal of a proposed decision or judicial review of final agency action, the appealing party is responsible for filing a transcript of the hearing.

If the hearing was electronically recorded, copies of the tape will be provided to the parties. A transcript shall be provided by the appealing party pursuant to Iowa Code subsection 86.24(4) and a copy thereof shall be served on the opposing party at the time the transcript is filed with the workers' compensation commissioner unless the parties submit an agreed transcript. If a party disputes the accuracy of any transcript prepared by the opposing party, that party shall submit its contentions to the workers' compensation commissioner for resolution. Any transcription charges incurred by the workers' compensation commissioner in resolving the dispute shall be initially paid pursuant to Iowa Code subsection 86.19(1) by the party who disputes the accuracy of the transcript prepared by the appellant.

4.48(13) Represented party. A party may be represented as provided in Iowa Code section 631.14. The presiding deputy may permit a party who is a natural person to be assisted during a hearing by any

person who does so without cost to that party if the assistance promotes full and fair disclosure of the facts or otherwise enhances the conduct of the hearing. The employer and its insurance carrier shall be treated as one party unless their interests appear to be in conflict and a representative of either the employer or its insurance carrier shall be deemed to be a representative of both unless notice to the contrary is given.

4.48(14) Decision. A decision will be issued within 10 working days of receipt of a proper application when a telephone hearing is held or within 14 working days of receipt of a proper application when an in-person hearing is held.

This rule is intended to implement Iowa Code sections 17A.12, 85.27, 86.8 and 86.17.

876—4.49(17A,85,86) Method of holding hearing. Any hearing held under this chapter may be by voice or video technology including but not limited to Internet-based video.

This rule is intended to implement Iowa Code sections 17A.12, 85.27, 86.8, 86.17 and 86.18.

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